STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010067	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY ADULT FAMILY HOME II	1009 MAYFAIR DR RACINE, WI 53402

(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 07/25/2025 to 07/31/2025, Surveyor conducted an abbreviated survey at Destiny Adult Family Home II. Three deficiencies were identified. Census: 4	M 000		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in all resident rooms. There was no smoke detector in Resident 1's room. Findings include: On 07/25/2025 at 8:50 AM, Surveyor conducted a tour of the facility with Lead Caregiver B.	M 334		

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

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M 334	Continued From page 1 Surveyor observed Resident 1's room. There was no smoke detector in Resident 1's room. Lead Caregiver B reported the batteries died and s/he would be replacing the smoke detector. Lead Caregiver B did not comment on how long Resident 1's smoke detector was missing for. On 07/31/2025 at 3:04 PM, Surveyor interviewed Licensee A. Licensee A reported staff had removed Resident 1's smoke detector because it needed new batteries, but staff forgot to put it back up. Licensee A stated s/he thought the smoke detector was missing for only a few days. Licensee A reported the smoke detector had been replaced after the Surveyor's visit.	M 334		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment appropriate for residents. The ceiling above the toilet had an approximate 3 feet (ft) by (x) 3 ft bubble that was swollen and sagging down.	M 570		

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M 570	Continued From page 2 Findings include: On 07/25/2025, Surveyor toured the facility and observed the following: At 8:44 AM, Surveyor toured the resident bathroom. Surveyor observed the ceiling above the toilet had an approximate 3 ft x 3 ft bubble that was swollen and sagging down. Surveyor felt the bubble and water was moving. In the same area, along the trim of the ceiling, Surveyor observed a mold-like substance speckled with small black dots (Photos #1811 and #1807). On 07/25/2025 at 9:00 AM, Surveyor interviewed Lead Caregiver B. Surveyor shared concerns regarding the water damage to the resident bathroom ceiling. Lead Caregiver B reported the facility had been dealing with leaking water from the upstairs bathroom on and off for the last 3 years. Lead Caregiver B stated their maintenance person had patched the ceiling in the past, but perhaps the ceiling and piping needed to be inspected. On 07/31/2025 at 3:04 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was aware of the condition of the ceiling in the resident bathroom. Licensee A reported the outer layer of the drywall had ballooned up after the upstairs toilet had leaked. Licensee A stated the issue had been fixed. Surveyor shared about the water still present in the bubble and the suspected mold-like substance observed along the ceiling trim. Licensee A stated s/he disagreed the bubble had any water in it and noted the mold-like substance should have been cleaned by staff. Licensee A stated s/he would have the ceiling fixed.	M 570		

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M 614	Continued From page 3	M 614		
M 614	88.11(3) INVESTIGATION OF ABUSE OR NEGLECT As soon as possible after being contacted under sub. (1) the licensing agency shall undertake an investigation of the reported abuse or neglect. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an investigation of abuse, made by Resident 2, was investigated. The police came to the facility on 06/12/2025 regarding allegations of abuse reported by Resident 2. The provider did not document an investigation into the alleged incident. Findings include: On 07/25/2025, Surveyor conducted an abbreviated survey and identified the following: On 07/25/2025 at 8:55 AM, Surveyor interviewed Resident 2. Resident 2 reported a few months back, Caregiver D had pushed him/her to the ground after s/he tried to take books to his/her bedroom that had been thrown away by Licensee A. Resident 2 stated the incident took place right outside his/her bedroom door. On 07/29/2025 at 1:43 PM, Surveyor interviewed Case Manager C regarding Resident 2's allegations of abuse. Case Manager C stated	M 614		

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M 614	Continued From page 4	M 614		

s/he had been Resident 2's case manager for over 5 years. Case Manager C reported s/he was unaware of any allegations of abuse from Resident 2 or from the provider. Case Manager C stated s/he was at their computer and reviewed Resident 2's record, and the record did not show any reports of alleged abuse. Case Manager C stated that Resident 2 was a reliable reporter. Case Manager C stated if Resident 2's guardian was made aware, s/he would have reported it to Resident 2's managed care organization team.

On 07/30/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 12/18/2023. Resident 2 had a legal guardian.

Resident 2's incident reports documented:
06/07/2025 completed by [Caregiver E]: "Around 5:30 PM, [Resident 2] was going out to the garbage getting books, etc. Staff told [him/her] that [s/he] can not [sic] bring books out the garbage in [his/her] room. [Resident 3] told on [Resident 2]. The staff went in room to off set [sic] the problem. [S/he] pushed lead staff. I called the owner, came by to talk with [Resident 2]."

06/07/2025 completed by [Caregiver D]: "@ (at) 5:30 PM, [Resident 2] was giving [staff] an issue about room search. [S/he] pushed out of way, [Resident 2] made a scene, fell to floor, staff came to defuse the issue. [Resident 2] yelling and being disrespectful to staff about [him/her] being to bring [sic] garbage out the dumpster. Told staff '[s/he] can do what [s/he] wants, when [s/he] wants, [s/he] didn't care' and told staff to [expletive] off as well."

06/12/2025 completed by [Caregiver F]: "Staff drop [Resident 2] off @ 6th & Main. [S/he] stated [s/he] wanted to go downtown. So around 11:45

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M 614	Continued From page 5 AM, a police officer came to the facility & (and) stated that one of the staff had roughed [Resident 2] up from going into the dumpster. Police offer stated that [Resident 2] said that [s/he] was going to the hospital if they wasn't going to do nothing about [Caregiver D]. Police Officer said that [s/he] came out to make sure that [Resident 2] wasn't being abused. Spoke with owner. No report filed. What actions were taken after the incident?: No incident report filed. Manager. Who was notified of the incident? Lead, manager/owner/CM/guardian." On 07/31/2025 at 3:04 PM, Surveyor interviewed Licensee A. Licensee A reported Resident 2 utilized public transportation and was able to go into the city without supervision. Licensee A reported Resident 2 could hold his/her own verbally. Licensee A reported s/he was aware of the abuse allegations after police came to the facility in June 2025. Licensee A reported s/he did not have evidence of an investigation being completed, everything done was verbally with staff and Resident 2. Licensee A stated s/he was unaware an investigation had to be documented. Licensee A reported s/he was worried about future reports of abuse and those investigations, because other residents make allegations of abuse if staff do not provide cigarettes.	M 614		