STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014243	A. BUILDING: _____ B. WING _____	R-C 10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE LIVING AFH LLC	7752 W BRENTWOOD AVE MILWAUKEE, WI 53223

(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 10/13/2025, Surveyor concluded a verification visit and a complaint investigation at Divine Living AFH LLC. Six deficiencies were identified. Three of 6 deficiencies were repeat deficiencies (see SOD KVYO11, dated 03/24/2025.) One complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 2	{M 000}		
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 interview and record review, the provider did not ensure the home and its operation complied with this chapter, which had the potential to affect 2 of 2 residents residing in the home. During the verification visit, 6 deficiencies were identified. Four of 6 deficiencies were repeat deficiencies. The licensee did not follow Department orders. The provider did not ensure staff receive training regarding the provider's written procedures required by Order #1. Findings include: The home is licensed to serve up to 4 adults in	M 216		

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

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M 216	Continued From page 1	M 216		

the population groups: advanced aged, correctional clients, developmentally disabled, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and physically disabled. The home can accommodate both ambulatory and non-ambulatory residents.

On 10/13/2025, Surveyor completed a complaint investigation, and a verification visit for SOD KVYO11, dated 03/24/2025. As a result, 6 deficiencies were identified. Three of 6 deficiencies were repeat deficiencies (see SOD KVYO11, dated 03/24/2025.)

The following deficiencies were identified:

88.04(2)(a) Responsibilities
88.06(3)(b) Persons Involved With ISP & Assessment (repeat)
88.06(3)(d) Individualized Service Plan (repeat)
88.06(3)(f) Review of ISP (repeat)
88.07(2)(b)4 Record of Medical Visits and Reports
88.10(3)(q) Medication

On 09/23/2025, Surveyor reviewed department documents and identified on 05/28/2025, the department issued SOD KVYO11, with a Notice and Order letter to Licensee A by email. The Notice and Order Letter contained Special Orders which stated, " 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 Divine Living AFH LLC:

1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., effective immediately, the licensee shall develop and implement corrective measures to

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M 216	Continued From page 2 ensure that residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency KVYO11. WITHIN 45 DAYS of receipt of this notice, the licensee's corrective measures shall include, at a minimum, the development (or review) of written procedures to address: Adequate Staffing - Establish notification requirements and duties in the event of management or service provider absences or emergencies. - Ensure staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services (e.g., toileting, bathing, medication management, interventions to prevent falls, personal cares, meals, leisure time activities), and to facilitate a safe evacuation of the building in the event of an emergency. - Ensure assigned staff will be separate and have distinct duties related to the care and services for residents at Divine Living AFH LLC. The assigned staff will not be shared with other programs. Health Monitoring, including how the provider will: - Monitor and document changes in the resident's physical or mental health. - Notify the resident's legal representative and care manager (if any) when a resident experiences a change of condition, accident, injury, or medical emergency. - Obtain timely medical care (clinical assessments, medications, prompt medical treatment).	M 216		

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M 216	Continued From page 3 - Provide or arrange services to address each resident's health care needs. Additionally: - All managers and service providers will receive training regarding the provider's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training. A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request." On 09/23/2025, at 11:05 a.m., Surveyor interviewed Licensee A regarding the Special Orders from the department. Licensee A reported s/he terminated several staff within the past month and the only staff that worked shifts was him/her and Caregiver R. Licensee A stated when either s/he or Caregiver R need time off, s/he contracted with a caregiving agency which went into effect on August 1st, 2025. Licensee A provided contract to Surveyor. Licensee A explained that s/he worked 24/7. Licensee A stated, "I barely go home. My back-up is the staffing agency for a break." On 09/23/2025 at 3:21 p.m., Licensee A forwarded his/her new policy and procedure booklet to Surveyor. Licensee A stated his/her new health monitoring policy was in the booklet. On 09/23/2025 at 3:28 p.m., Licensee A forwarded his/her new change in condition policy to Surveyor, which was in his/her new policy and procedure booklet.	M 216		

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M 216	Continued From page 4 On 09/23/2025 at 3:28 p.m., Licensee A confirmed s/he did not complete the remaining special orders including the training of his/her written procedures, the documented date/duration of the trainings, the signature/qualifications of the instructor, and evidence of the successful completion of the training.	M 216		
{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 1 of 2 residents' (Resident 2) Individual Service Plan (ISP) were reviewed and developed together with the placing agency, the person being admitted or person's guardian / designated representative and the provider. This is a repeat deficiency. See Statement of Deficiency (SOD) KVYO11, dated 03/24/2025. Findings include:	{M 406}		

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{M 406}	Continued From page 5 On 9/23/2025 at 11:20 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the home on 12/01/2023. Resident 2's individualized service plan (ISP) was dated 07/27/2025. There were no signatures of agreement on Resident 2's ISP. On 09/23/2025 at 11:43 a.m., Surveyor interviewed Licensee A. Licensee A stated s/he emailed Resident 2's ISP to Resident 2's managed care organization (MCO) team, during survey. Licensee A confirmed, "The ISP is worthless. Guardian E did not sign [Resident 2's] ISP." On 10/11/2025 at 10:21 a.m., Licensee A emailed Surveyor a copy of a link to Resident 2's Managed Care Organization (MCO) service plan signature page dated 08/12/2025. Surveyor observed Care Manager (CM) Q and CM R's signatures included with Licensee A.	{M 406}		
{M 410}	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident's Individual Service Plan (ISP) accurately	{M 410}		

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{M 410}	Continued From page 6 identified Resident 3's current needs and abilities. Resident 3's ISP did not identify monitoring guidelines for his/her Risperdal injections. This is a repeat deficiency. See Statement of Deficiency (SOD) KVYO11, dated 03/24/2025. Findings include: On 9/23/2025 at 12:00 p.m., Surveyor reviewed Resident 3's record. The following was identified: Resident 3 was admitted to the home on 07/09/2024, with diagnoses including schizoaffective disorder, cocaine use disorder, acute and chronic respiratory failure with hypoxia, alcohol abuse, cardiac arrest, chronic obstructive pulmonary disease with acute exacerbation, epilepsy and primary hypertension. Resident 3 had a legal guardian. Resident 3 was enrolled in services with a managed care organization (MCO), Milwaukee County Department of Health and Human Services program called Wisconsin Community Services (WCS) and was assigned case managers. On 09/23/2024, Physician L signed the admission order, that indicated, "Medications are to be administered by designated staff, may crush appropriate medications as indicated." On 09/23/2025 12:36 p.m., Licensee A forwarded an email correspondence between the managed care organization (MCO) team, Licensee A and Guardian I from the dates of 01/30/2025 to 04/06/2025. -On 03/20/2025 at 2:24 p.m., Licensee A stated in	{M 410}		

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{M 410}	Continued From page 7	{M 410}		

email to Care Manager H, "[Resident 3] can remain admission with Divine Living only with condition that Wisconsin Community Services (WCS) come monthly for his/her injections in a timely manner."

-On 04/03/2025 at 9:29 a.m., Care Manager H responded, "We can discuss the conditions with WCS regarding his/her monthly injections being done in a timely manner ... I've reached out and WCS Care Team will be at meeting to discuss frequencies of injections as well."

On 09/23/2025 2:22 p.m., Licensee A forwarded Resident 3's physician orders dated 02/10/2025 from WCS pharmacy.

Interviews

On 09/23/2025 at 1:30 p.m., Surveyor interviewed Licensee A about the location of Resident 3's ISP. Licensee A stated everybody signed Resident 3's ISP, s/he just could not locate it. Licensee A confirmed, "I don't have it." On 10/02/2025 at 10:00 a.m., Surveyor reviewed the department files for Statement of Deficiency (SOD) KVYO11 dated 03/24/2025 and identified Resident 3's ISP, which was un-dated.

Resident 3's ISP did not accurately identify and describe Resident 3's medication regimen and services provided by outside agencies. Resident 3's ISP did not document that Resident 3 required injections every other week to manage his/her schizophrenia symptoms.

On 10/02/2025 at 1:20 p.m., Surveyor interviewed Lead Supervisor Wisconsin Community Services (LSWCS) J, who stated, they have been working with Resident 3 for years, long before s/he moved

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{M 410}	Continued From page 8 into the facility. LSWCS J confirmed, "[Resident 3] was receiving Risperdal injections for psychiatric symptoms before s/he moved into facility."	{M 410}		
{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 observation, record review and interview, the provider did not ensure 1 of 1 resident (Resident 2) Individual Service Plan (ISP) accurately identified the descriptions of services provided by outside agencies. This is a repeat deficiency. See Statement of Deficiency (SOD) KVYO11, dated 03/24/2025. Findings include:	{M 424}		

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{M 424}	Continued From page 9 On 09/23/2025, Surveyor reviewed Resident 2's record and identified the following: - Resident 2 was admitted to the provider's home on 12/01/2023. - Resident 2 had a case manager (CM) from a managed care organization (MCO) and a guardian. On 09/23/2025, Surveyor reviewed Resident 2's individualized service plan (ISP) dated 07/27/2025. The following was identified: Social participation. Community contacts. No community contacts. Resident's needs/preferences: "Has no contacts within the community." Resident's desired goals and outcomes: "Maintain meaningful activities attending day program." Service provider responsibilities: "Staff/adult family home (AFH)." Measurable goals, outcomes and review: "Maintain meaning [sic] full activities attending day program." Resident 2's ISP did not indicate on what days and times Resident 2 went to day program and how s/he was transported to and from the activity. Interviews On 09/23/2025 at 9:15 a.m., Surveyor interviewed Caregiver K, who stated Resident 2 was in day program Monday through Friday from around 9:00 a.m. to about 3:00 p.m. On 09/23/2025 at 1:35 p.m., Surveyor interviewed Licensee A and requested him/her to identify the days, times and how Resident 2 was transported	{M 424}		

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{M 424}	Continued From page 10 to his/her day program on the ISP. Licensee A confirmed that information was not on Resident 2's ISP. Licensee A stated everybody signed Resident 2's ISP, s/he just could not locate signatures. Licensee A confirmed, "I don't have it signed by anyone." On 09/23/2025 at approximately 4:00 p.m., Surveyor observed Resident 2 return from his/her day program.	{M 424}		
M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure they obtained a record of all medical visits and reports for 1 of 1 resident. Resident 3 had a mental health diagnosis and required medication for treating his/her symptoms. The provider did not track or monitor Resident 3's Risperdal injections. Findings include: On 9/23/2025 at 12:00 p.m., Surveyor reviewed Resident 3's record. The following was identified: Resident 3 was admitted to the home on 07/09/2024, with diagnoses including schizoaffective disorder. On 09/23/2025 at 8:00 a.m., Surveyor reviewed Resident 3's records received from managed care organization. The following was identified:	M 446		

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M 446	Continued From page 11 -On 07/08/2025, Interdisciplinary team (IDT) conducted a face-to-face assessment. The assessment read, "No changes to medications as [Resident 3] received them daily from Wisconsin Community Services (WCS) team and CM (case manager) supervisor will update IDT on any other changes ... [Resident 3] also continue to receive weekly visit from WCS staff along with monthly injections and to see psychiatrist." On 09/23/2025 2:07 p.m., Surveyor interviewed Licensee A and asked how s/he tracked Resident 3's Risperdal injections. Licensee A stated, "We didn't track any of it. The WCS staff would just show up and take [Resident 3] out for his/her injection." Surveyor questioned Licensee A on how s/he was able to track Resident 3's refusals. Licensee A stated, "We didn't document any of that, because WCS was responsible for all of that. WCS should have that documented, not us." On 09/23/2025 2:17 p.m., Licensee A confirmed Resident 3's Risperdal injections were not on the facility medication administration record. Licensee A confirmed s/he did not monitor Resident 3's mental health medication and explained s/he understood s/he should be as a part of caring for Resident 3 as a whole person. Licensee A stated, "I learn something every time State comes." Cross Reference M0410 DHS 88.06(3)(d) Individualized Service Plan Cross Reference: M0582 DHS 88.10(3)(q) Medications	M 446		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage	M 582		

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M 582	Continued From page 12 and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on records review and interviews, the provider did not ensure 1 of 1 resident received all prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 3 was seen in the emergency room (ER) on 07/19/2025 for shortness of breath, hyponatremia, and hypo-osmolality. Resident 3 was prescribed azithromycin for infection, prednisone for inflammation/swelling, and furosemide for water retention. The provider did not fill the medications. Resident 3 passed away on 07/21/2025. Findings include: On 09/04/2025, the department received a concern stating the facility was mismanaging medications. On 09/23/2025 at 8:00 a.m., Surveyor reviewed Resident 3's records received from managed care organization (MCO) on 09/23/2025 10:15 a.m. The following was identified: -On 07/21/2025, Nurse Care Manager (RNCM) O documented in Resident 3's MCO case note. RNCM O received multiple email correspondences from Licensee A. S/He sent	M 582		

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M 582	Continued From page 13 RNCM O pictures of pages 1, 2, 3, and 5 of the after-visit summaries. There was a total of 11 pages to be noted as the entire document. Licensee A reported Resident 3 was prescribed new medications on 07/19/2025 following his/her emergency room (ER) visit but stated that Wisconsin Community Services (WCS) did not deliver the medications. RNCM O consulted with Care Manager (CM) P, who reported the medications were only delivered to the resident Monday through Friday prior to 3:00 p.m. -On 07/21/2025 a provider concern was filed by the managed care organization (MCO) related to Health/Safety and Medication Management with Licensee A. The concern narrative read, "[Resident 3] was seen in the ER on 7/19/25 for shortness of breath, hyponatremia, and hypo-osmolality. It was reported by [Licensee A] that WCS did not deliver [Resident 3's] newly prescribed medications for him/her to begin taking as soon as possible. However, WCS does not provide medication management/medication administration services over the weekend. [Resident 3] was prescribed Azithromycin for infection, Prednisone for inflammation/swelling, and Furosemide for water retention. These medications were never filled, and [Resident 3] did not begin taking them following his/her ER visit ...[Resident 3's] medications should have been filled, and staff should have attempted to administer the medications as prescribed. If [Resident 3] refused the medications, as s/he would do sometimes, staff could have documented the refusals in the MAR (medication administration record)." - On 07/21/2025, RNCM O documented MCO case note, "IDT received an email correspondence from [Licensee A] reporting that	M 582		

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	0014243	A. BUILDING: _____ B. WING _____	R-C 10/13/2025

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M 582	Continued From page 14 [Resident 3] was found deceased [sic] lying in his/her bed this morning." -Initial Actions Taken: Suspension from New Referrals. On 9/23/2025 at 12:00 p.m., Surveyor reviewed Resident 3's record. The following was identified: Resident 3 was admitted to the home on 07/09/2024, with diagnoses including schizoaffective disorder, cocaine use disorder, acute and chronic respiratory failure with hypoxia, alcohol abuse, cardiac arrest, chronic obstructive pulmonary disease with acute exacerbation, epilepsy and primary hypertension. Resident 3 had a legal guardian. Resident 3 was enrolled in services with a managed care organization (MCO) and was assigned case managers. On 09/23/2025 12:15 p.m., Licensee emailed Surveyor Resident 3's incomplete after visit summary (AVS) dated 07/19/2025. Licensee A provided Surveyor 4 of 11 pages of the AVS. The following was identified: "- [Resident 3] was seen in the emergency room (ER) for shortness of breath, hyponatremia, and hypo-osmolality. - [Resident 3]'s diagnosis were COPD exacerbation and hyponatremia." The AVS instructions read: "- It is important that you use your oxygen one to two liters with your oxygen concentrator around the clock. - We will put you on a course of prednisone and antibiotic. - Limit water intake to 8 ounces per day. We'll	M 582		

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also give three days of furosemide.
- If you have increased problems of shortness of breath, confusion please return to emergency department.
- Read the attached information. Chronic obstructive pulmonary disease (COPD) discharge instructions.
- Pick up these medications at Wisconsin Community Services (WCS) Clinic Pharmacy. Azithromycin, Prednisone and Furosemide.
-Follow up with your personal care physician (PCP) in 3 days (around 7/22/2025)."

On 09/23/2025 12:36 p.m., Licensee A forwarded an email correspondence between the managed care organization (MCO) team, Licensee A and Guardian I from the dates of 01/30/2025 to 04/06/2025. The following was identified:

On 03/20/2025 at 2:24 p.m., Licensee A stated in email to Care Manager H, "[Resident 3] can remain admission with Divine Living only with condition that Wisconsin Community Services (WCS) come monthly for his/her injections in a timely manner."

On 04/03/2025 at 9:29 a.m., Care Manager H responded, "We can discuss the conditions with WCS regarding his/her monthly injections being done in a timely manner ... I've reached out and WCS Care Team will be at meeting to discuss frequencies of injections as well."

On 09/23/2025 1:15 p.m., Surveyor reviewed Resident 3's electronic chart notes dated 07/21/2025 at 11:04 a.m. Caregiver M documented, "[Resident 3] Went to hospital on 7/19 for oxygen/breathing treatment [sic] s/he refused but s/he also had a chest Xray. [sic] Xray [sic] came back fine. [sic] hospital sent him/her

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M 582	Continued From page 16 back home [sic]" On 09/23/2025 2:45 p.m., Surveyor reviewed Resident 3's incident report dated 07/21/2025. Licensee A wrote, "WCS Pharmacy did not deliver resident post hospital medication. Member went to emergency room (ER) on 07/19/2025 and returned same day [sic] without notice from [hospital]. Hospital sent script to WCS Pharmacy. Which was close [sic] until Monday. Immediate action. Notified WCS closed on 07/20/2025 which was Sunday. [sic] 07/21/2025 Pharmacy stated meds were being delivered and asked if member was expired. Notifications. WCS." On 10/09/2025 at 1:40 p.m., Licensee A emailed Surveyor, "I have [Resident 3's] death certificate and it had nothing to do with medication." Surveyor requested Licensee A provide a copy of Resident 3's death certificate. On 10/13/2025 9:57 a.m., Surveyor received a copy of Resident 3's death certificate via email. Resident 3's death certificate read, "Cause of death (chain of events leading directly to death): A. Arrhythmia. Interval between onset and death: Minutes. B. Coronary heart disease. Interval between onset and death: Years. C. Atherosclerosis. Interval between onset and death: Years." Interviews On 09/23/2025 at 9:32 a.m., Licensee A stated s/he was not working when Resident 3 arrived back to the facility from emergency room on 07/19/2025. "Residents usually come home with paperwork, and I look it over. I look for changes. It's common sense. The caregiver did not do that	M 582		

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with Resident 3's after visit summary."

On 09/23/2025 12:05 p.m., Surveyor asked Licensee A what the ER recommended for Resident 3 after s/he arrived home. Licensee A stated the emergency room gave Resident 3 new prescriptions and recommended that they be filed and started.

On 09/23/2025 at 12:21 p.m., Licensee A stated WCS oversaw Resident 3's medication. Licensee A explained that Resident 3 was with facility's pharmacy and Licensee A was giving Resident 3 his/her Risperdal injections. Back in February of 2025, Resident 3 started to refuse his/her medications, so the managed care organization (MCO) had WCS begin bringing Resident 3's medications in bubble packs. WCS was Resident 3's pharmacy and service provider. They would also pick him/her up and take him/her up to get his/her injections. When Resident 3 was sent home from the ER, the hospital electronically prescribed everything to the WCS pharmacy. However, they are closed on weekends. Licensee A stated s/he could not get the medications for Resident 3, since they were already at WCS.

On 09/23/2025 1:40 p.m., Surveyor asked what new interventions were put in place after this incident occurred. Licensee stated s/he would no longer accept weekend readmissions. Licensee A stated, "[Resident 3] came home on a weekend when the pharmacy was closed. I saw the after-visit summary after s/he had already died."

On 09/23/2025 1:47 p.m., Licensee A expressed s/he was frustrated, and stated, "My MCO has suspended me due to medication errors. This is too much."

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M 582	Continued From page 18 On 10/02/2025 at 1:20 p.m., Surveyor interviewed Lead Supervisor Wisconsin Community Services (LSWCS) J, who stated, they have been working with Resident 3 for years, long before s/he moved into the facility. LSWCS J confirmed, "[Resident 3] was receiving Risperdal injections for psychiatric symptoms. [Licensee A] was supposed to be administering injections, however, [Resident 3] constantly refused with him/her. From July 2024 until February 2025, [Licensee A] tried to manage [Resident 3]'s medication. WCS and the MCO had care conferences with [Licensee A]. S/He would complain and verbally issue 30-day notices to Resident 3. It was a frequent occurrence." On 10/02/2025 at 1:40 p.m., LSWCS J confirmed, "[Licensee A] knew our pharmacy was closed on the weekend." Cross Reference M 410 DHS 88.06(3)(d) Individualized Service Plan	M 582		