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 _____	C 10/20/2025

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 10/20/2025, Surveyors completed 1 complaint investigation at Destiny Adult Family Home II. As a result, 1 deficiency was identified, and 1 complaint was substantiated. Census: 4	M 000		
M 434	88.07(1)(e) Supervision The licensee shall arrange for a service provider to be present in the home when the licensee is gone overnight or when the licensee's absence prevents the resident from receiving the services, training or supervision specified in the resident's individual service plan under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for a service provider to be present in the home when a resident requires services or supervision for 1 of 2 residents (Resident 1). Resident 1 was left unsupervised during a planned outing for the facility. Findings include: On 10/01/2025, the Department received 1 complaint alleging concerns with supervision. On 10/20/2025, at 9:10 AM, Surveyors reviewed Resident 1's file. Resident 1 was admitted on 12/18/2023, with diagnoses including cognitive disorder and personality disorders. Resident 1's individual service plan (ISP), dated 06/18/2025,	M 434		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY ADULT FAMILY HOME II	**1009 MAYFAIR DR RACINE, WI 53402**

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M 434	Continued From page 1 indicated Resident 1 required 24-hour supervision and indicated the comment "protective placement". Surveyors did not review an assessment in Resident 1's file or any area in Resident 1's ISP to indicate when and where Resident 1 required 24-hour supervision or if s/he was safe to be in the community or in the home without supervision. On 10/20/2025, at 10:15 AM, Surveyors interviewed Resident 1. Resident 1 reported s/he walks to the grocery store and convenience store unsupervised weekly. Resident 1 reported s/he walks around the neighborhood weekly unsupervised. Resident 1 reported the facility has outings s/he does not always attend. Resident 1 reported s/he would stay at the facility or leave unsupervised during outings s/he did not want to attend. On 10/20/2025 at 10:50 AM, Surveyors interviewed Licensee A and Caregiver B. Surveyors inquired about Resident 1's 24-hour supervision requirements. Licensee A confirmed Resident 1 was under court ordered protective placement. Licensee A reported Resident 1 "always had freedom to go where [she/he] wants". Licensee A confirmed Resident 1 walks to the convenience store and takes public transportation unsupervised. Licensee A reported Resident 1 did not attend a planned facility outing on 09/12/2025. Licensee A reported Resident 1 left the facility and returned before the planned outing was over and no staff were present at the facility. Licensee A confirmed Resident 1 was outside the facility, and unable to go inside, when Adult Protective Services (APS) arrived at the facility on 09/12/2025. Licensee A reported Resident 1's 24-hour supervision not being updated was an "oversight". Licensee A reported	M 434		

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 _____	C 10/20/2025

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 434	Continued From page 2 s/he would update the ISP and Resident 1's managed care organization of supervision changes.	M 434		