STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009870	A. BUILDING: _____ B. WING _____	C 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A PLACE FOR MIRACLES LIV CTR	5100 N 42ND ST MILWAUKEE, WI 53209

(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
N 000	Initial Comments On 01/10/2025, Surveyor concluded a standard survey and two complaint investigations at A Place For Miracles Living Center, LLC. As a result, 8 deficient practices were identified. One of 8 deficiencies was a repeat violation (See SOD F23011 dated 06/01/2020). Two complaints were unsubstantiated. Census: 5	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not submit a written report to the department within 3 working days after an incident or accident resulting in serious injury requiring emergency room treatment for 1 of 1 resident (Resident 6) reviewed. On 09/06/2024, Resident 6 had an unwitnessed fall and sustained cut to his/her head. Resident 6 was sent to the emergency room. There was no evidence the provider reported this incident to the State Agency. Findings include:	N 165		

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

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N 165	Continued From page 1 On 12/27/2024 at approximately 11:25 a.m., Surveyor reviewed Resident 6's record. The following was identified: Resident 6 was admitted on 11/08/2021 with diagnoses of Huntington's disease, trauma syndrome with on sporadic duration, autism, pneumonia and acute respiratory failure. Resident 6's record indicated staff were responsible for administering her/his medications. Resident 6 had an Activated Healthcare Power of Attorney. Resident 6 was discharged after 09/09/2024. FACILITY INCIDENT REPORT 09/06/2024: Caregiver C wrote s/he was assisting other residents in the kitchen and heard a loud boom. Caregiver C went into the dining area and Resident 6 was on the floor with the chair on top of him/her. Caregiver C wrote, "[Resident 6] was bleeding from the head. Staff helped [Resident 6] up and [sic] called manager and ambulance." Resident 6 was transported to the hospital via ambulance. MANAGED CARE CASE NOTES 09/06/2024: Care Manager D received a telephone call from Licensee A. S/He indicated Resident 6 had a fall, cut his/her head was sent to the emergency room. On 12/27/2024 at 1:32 p.m., Surveyor interviewed Licensee A, who stated within last month of Resident 6 living at the facility, s/he had a fall in the kitchen. Caregiver C sent him/her out to the emergency room because s/he had a cut on his/her head.	N 165		

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N 165	Continued From page 2 CLEMENT J. ZABLOCKI VA MEDICAL CENTER 09/06/2024: [Resident 6] was seen in Emergency Room at Clement J. Zablocki VA Medical Center. The document read, "This information is about your illness and diagnosis. Laceration closed with staples." DEPARTMENT RECORDS On 12/27/2024, Surveyor reviewed the provider's self-report history. The Department did not receive a self-report for Resident 6's fall on 09/06/2024, resulting in an emergency room visit and a cut to his/her head. On 01/10/2025 at 3:00 p.m., Surveyor interviewed Licensee A who stated, "I reported the incident to [Guardian H] and [Care Manager F]. I guess I should review the codes." Licensee A confirmed s/he did not report the incident to the department.	N 165		
N 283	83.26(1) Documentation of required employee training The CBRF shall maintain documentation of all employee training under s. DHS 83.21 and task specific training under s. DHS 83.22 and shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers (Caregiver B and Caregiver G) received at least 15 hours of continuing education in 2024 that was	N 283		

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N 283	Continued From page 3 relevant to the job responsibilities and included, at a minimum, all of the following: standard precautions; client group related training; medications; resident rights; prevention and reporting of abuse, neglect and misappropriation; fire safety and emergency procedures, including first aid. Findings include: On 12/27/2024 at 1:45 p.m., Surveyors requested Caregiver B and Caregiver G records. Licensee A stated the records were at his/her office. Caregiver B had a start date of 06/28/2021. No evidence of continuing education training was provided. Caregiver G had a start date of 01/01/2019. No evidence of continuing education training was provided. On 12/27/2024, at 2:00 p.m., Surveyor gave Licensee A until 12/30/2024, at 3:00 p.m. to provide documentation. As of 01/10/2025 at 12:00 p.m., no additional information was received.	N 283		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following:	N 310		

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N 310	Continued From page 4 (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure an admission agreement was signed and dated before or at the time of admission for 1 of 1 resident reviewed (Resident 6). Findings include: Between 12/27/2024 and 01/10/2025, Surveyor	N 310		

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N 310	Continued From page 5 reviewed Resident 6's record and identified the following: -Resident 6 was admitted on 11/08/2021 with diagnoses of Huntington's disease, trauma syndrome with on sporadic duration, autism, pneumonia, and acute respiratory failure. -Resident 6 had an Activated Healthcare Power of Attorney. -Resident 6 was admitted to the hospital on 09/09/2024. -Resident 6 was discharged from the hospital on 10/04/2024 to another Community Based Residential Facility (CBRF.). -Resident 6's record did not contain a signed admission agreement. On 12/27/2024 at 1:30 p.m., Surveyor requested Resident 6's signed admission agreement from Licensee A. On 01/10/2025 at 3:10 p.m., Surveyor requested Resident 6's signed admission agreement from Licensee A. On 01/10/2025 at 3:15 p.m., Licensee A stated s/he would look for the admission agreement and send to Surveyor no later than 01/11/2025 at 5:00 p.m. As of 01/11/2025 at 5:00 p.m., no further information had been received.	N 310		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30	N 326		

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N 326	Continued From page 6	N 326		

day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not provide a 30-day written notice of discharge for 1 of 1 resident who was hospitalized. Resident 6 was hospitalized on 09/09/2024, and the provider did not accept him/her back to the facility. Resident 6 was later discharged from the hospital to another community based residential facility (CBRF).

Findings include:

Between 12/27/2024 and 01/10/2025, Surveyor reviewed Resident 6's record and identified the following:

-Resident 6 was admitted on 11/08/2021 with diagnoses of Huntington's disease, trauma syndrome with on sporadic duration, autism, pneumonia, and acute respiratory failure.
-Resident 6 had an Activated Healthcare Power of Attorney.
-Resident 6 was admitted to the hospital on 09/09/2024.
-Resident 6 was discharged from the hospital on 10/04/2024 to another CBRF.
-Resident 6's record did not contain a 30-day

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N 326	Continued From page 7 written notice of discharge. FACILITY INCIDENT REPORT 09/08/2024: Caregiver F documented Resident 6 stood up from his/her chair and fell face first onto floor. Licensee A assisted Resident 6 to his/her feet. S/He was bleeding from his/her nose and mouth. Licensee A assisted Resident 6 to bathroom to slow the bleeding and called 911. The ambulance took him/her to the Emergency Room at Clement J. Zablocki VA (Veterans Administration) Medical Center. MANAGED CARE CASE NOTES 09/09/2024: Care Manager (CM) D received a telephone call from Licensee A. S/He indicated [Resident 6] had a fall on 09/08/2024 and was transported to the VA hospital where s/he was treated and then returned to the CBRF later that evening. Licensee A reported Resident 6 had, what appeared to be, a seizure on 9/9/2024. Licensee A sent him/her out to the VA hospital again. CM D wrote, "Licensee says s/he will not be able to accept member back to CBRF as s/he only has one staff person per shift for all residents (up to 8) in the CBRF. [Licensee A] feels [Resident 6] is not safe with his/her staff to resident ratio and is at risk for further injury knowing [Resident 6] is likely to continue to be a high risk due to members Huntington's disease." On 12/27/2024 at 1:32 p.m., Surveyor interviewed Licensee A, who reported Resident 6 had an unwitnessed fall on 09/06/2024 where s/he sustained cut to his/her head and was transported to the emergency room for staples in his/her head. Resident 6 returned to the facility	N 326		

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N 326	Continued From page 8	N 326		

the same day. On 09/08/2024, Resident 6 had another fall after standing up from the couch. S/He cut his/her lip and was sent out to the emergency room. Resident 6 returned to the facility the same day. On 09/09/2024, Resident 6 had what appeared to be a seizure with tremors. Resident 6 was sent out to the emergency room. Licensee A stated, "I couldn't take [Resident 6] back after that. S/He needed 1:1 care due to his/her decline. Our one staff could not continue to follow [Resident 6] around to be sure s/he was safe and neglect the other residents. I never went to the hospital to reassess [Resident 6] after that last fall. I just couldn't take him/her back." Licensee A confirmed the hospital did not have anywhere to place Resident 6.

On 01/08/2025 at 1:15 p.m., Surveyor interviewed Nurse Care Manager (RN CM) E, who reported Resident 6 was having falls at the facility. Licensee A did not feel like they could care for Resident 6 any longer. Resident 6 went to the emergency room after a fall on 09/09/2024. Licensee A called RN CM E and Care Manager D and explained s/he could not take Resident 6 back into the facility after that. RN CM E stated, "[Resident 6] was in the hospital with nowhere to go because s/he would not take him/her back. I can't believe there is not a better way to do that."

On 01/10/2025, at 3:05 p.m., Licensee A stated when Resident 6 went to the hospital on 09/09/2024, s/he knew Resident 6 needed more care. Licensee A stated, "We could not provide it without 1:1 care. We did not give [Resident 6] a 30-day discharge notice."

Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury

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N 386	Continued From page 9	N 386		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not develop and implement a comprehensive Individual Service Plan (ISP) for 1 of 1 resident reviewed (Resident 2). Resident 2 would take bathroom paper towel and hoard it. The provider began to restrict the paper towel use for all residents due to Resident 2's hoarding behaviors. Residents 2's ISP did not address Resident 2's behavior of hoarding paper towels. The ISP did not include program service approaches to be provided, established measurable goals with specific time limits for attainment, specified methods for delivering needed care, and who was responsible for delivering his/her care. Findings include:	N 386		

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N 386	Continued From page 10 On 12/27/2024 at 12:30 p.m., Surveyor reviewed Resident 2's record. Surveyor received a copy of Resident 2's ISP, generated from an electronic medical records database, dated 12/31/2024. Surveyor was unable to locate the complete record for Resident 2. On 12/27/2024, at 2:00 p.m., Surveyor gave Licensee A until 12/30/2024, at 3:00 p.m. to provide documentation. On 12/30/2024 at 11:20 p.m., Licensee A emailed Surveyor Resident 2's admission agreement dated 05/09/2023, grievance procedure, dated 05/09/2023, Resident 2's hand-written individualized service plan (ISP), dated 05/18/2022, and Resident 2's typed ISP, dated 05/18/2022, containing guardian signature and no date. Between 12/27/2024 and 01/10/2025, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted on 05/18/2022 with diagnoses of Huntington's disease, trauma syndrome with on sporadic duration, autism, pneumonia, and acute respiratory failure. -Resident 2 had a guardian since 03/30/2022. Resident 2's admission agreement, dated 05/09/2023, read, "Each resident has the right to promote treatment and supportive services appropriate to their needs. Resident's also have the right to the least restrictive conditions necessary to achieve the purpose of their admission. A place for miracles living center accepts as policy, the client Bill of Rights ...Fair treatment: to be treated with courtesy, respect	N 386		

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N 386	Continued From page 11	N 386		

and full recognition of the resident's dignity and individuality by all employees of the facility ...Least restrictive conditions: To have the least restrictive conditions necessary."

Resident 2's preadmission assessment, dated 04/29/2022, under cognition read, "Memory: Poor. 'Long term is good. Short term memory is poor'. Known Triggers: n/a. Successful interventions: no behaviors. Mood/behavior, Dx (diagnosis) of: None."

On 01/10/2025, at approximately 2:55 p.m., Surveyor interviewed Licensee A about Resident 2's ISP generated from an electronic medical records database, dated 12/31/2024.. Surveyor interviewed Licensee A, who stated, "I don't really know what date this ISP is from. No one ever signed [Resident 2's] ISP."

Surveyor asked Licensee to point out Resident 2's specific program approaches to be provided regarding his/her paper towel hoarding, what the goals with specific time limits for attainment were and what methods were caregivers to utilize for delivering Resident 2's care. Licensee A stated that information was not in Resident 2's ISP.

Residents 2's ISP did not include program service frequency, approaches to be provided, established measurable goals with specific time limits for attainment, specified methods for delivering needed care, who was responsible for delivering his/her care.

On 12/27/2024, at 11:15 a.m., Surveyor informed Caregiver B that there were no single use paper towels in the bathroom. Caregiver B stated, "We cannot put full rolls of paper towels in the bathroom because of [Resident 2]. S/He is a

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N 386	Continued From page 12 hoarder." Surveyor asked Caregiver B how residents received single use paper towels. Caregiver B stated, "We have to give each resident single use paper towels as they go in the bathroom from the kitchen dispenser." Surveyor confirmed with Caregiver B that the downstairs bathroom was the residents' primary bathroom. On 12/27/2024, at 11:25 a.m., Surveyor interviewed Licensee A regarding the empty towel dispenser in the main resident bathroom. Licensee A stated Resident 2 was had hoarding behaviors and they had to hand the paper out separately to each resident. Licensee A reported, "We monitor the residents often. They like to keep them in their pockets. Especially [Resident 2]. It gets expensive." Surveyor asked if Resident 2's hoarding of single use paper towels was in his/her individualized service plan (ISP). Licensee A confirmed it was not part of Resident 2's ISP. On 01/10/2025, at approximately 3:30 p.m., Surveyor interviewed Licensee A, who confirmed Resident 2's ISP did not include specific program approaches to be provided regarding his/her paper towel hoarding, what his/her goals with specific time limits for attainment were and what methods the caregivers utilized for delivering Resident 2's care.	N 386		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years.	N 530		

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N 530	Continued From page 13 This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual inspection by the local fire authority or certified fire inspector and retain the report for 1 of 2 years reviewed (2024). Findings include: This facility is licensed to care for 6 residents in the client groups of: irreversible dementia Alzheimer's, public funding, developmentally disabled, emotionally disturbed/mental illness, and advanced age. On 12/27/2024, Surveyor reviewed facility safety records on site. Surveyor was unable to locate the local fire authority inspection for 2024. On 12/27/2024, at 2:00 p.m., Surveyor gave Licensee A until 12/30/2024, at 3:00 p.m. to provide documentation. On 01/02/2025 at 4:45 p.m., Licensee A faxed Surveyor the facility's safety reports. The fax did not include documentation for 1 of 2 fire inspections required (2024). On 01/02/2025 at 4:50 p.m., Surveyor reviewed the provider's department file, and no waivers for fire inspections were filed. On 12/27/2024, at approximately 1:55 p.m., Surveyor interviewed Licensee A, who stated, the fire inspection was not conducted in 2024. Licensee A stated, "By the time I tried to schedule it, the fire inspector was retired. So, I did not get it done this year."	N 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009870	A. BUILDING: _____ B. WING _____	C 01/10/2025

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N 538	Continued From page 14	N 538		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the fire detection system was inspected, cleaned, and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer's specifications and procedures for the years 2023 and 2024. Findings include: This facility is licensed to care for 6 residents in the client groups of: irreversible dementia Alzheimer's, public funding, developmentally disabled, emotionally disturbed/mental illness, and advanced age. On 12/27/2024 at 1:55p.m., Surveyor reviewed facility safety records for evidence the fire detection system was inspected, cleaned, and tested in 2023 and 2024 by a certified or trained and qualified personnel. Surveyor was unable to locate evidence that the fire detection system was inspected. On 12/27/2024, at 2:00 p.m., Surveyor gave Licensee A until 12/30/2024, at 3:00 p.m. to provide documentation. On 01/02/2025 at 4:45 p.m., Licensee A faxed	N 538		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 538	Continued From page 15 Surveyor the facility's safety reports. The fax did not include an annual smoke and heat detector inspection for 2023 and 2024. On 01/10/2025, at approximately 2:55 p.m., Surveyor interviewed Licensee A, who confirmed the fire detection system was not inspected, cleaned, and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer's specifications and procedures for the years 2023 and 2024. Licensee A stated, "We've got the inspection booked for two weeks from now."	N 538		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all bathrooms used by residents and staff had functioning dispensers for single use paper towels for 1 of 2 dispensers. One of two 2 bathrooms' paper towel dispensers were empty. Findings include: On 12/27/2024 at 10:35 a.m., at Surveyor observed the bathroom in the hallway by the resident bedrooms on the first floor. There were no single use paper towels to dry hands present	N 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009870	A. BUILDING: _____ B. WING _____	C 01/10/2025

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N 612	Continued From page 16 in the bathroom. On 12/27/2024, at 11:15 a.m., Surveyor informed Caregiver B that there were no single use paper towels in the bathroom. Caregiver B stated, "We cannot put full rolls of paper towels in the bathroom because of [Resident 2]. S/He is a hoarder." Surveyor asked Caregiver B how residents received single use paper towels. Caregiver B stated, "We have to give each resident single use paper towels as they go in the bathroom, from the kitchen dispenser." Surveyor confirmed with Caregiver B that the downstairs bathroom was the resident's primary bathroom. On 12/27/2024, at 11:25 a.m., Surveyor interviewed Licensee A regarding the empty towel dispenser in the main resident bathroom. Licensee A stated Resident 2 was a hoarder and they had to hand the paper out separately to each resident. Licensee A reported, "We monitor the residents often. They like to keep them in their pockets. Especially [Resident 2]. It gets expensive." Surveyor asked if Resident 2's hording of single use paper towels was in his/her individualized service plan (ISP). Licensee A confirmed it was not part of Resident 2's ISP and behavioral support plan. Surveyor observed bathroom dispenser out of hand towels from 10:35 a.m. to 2:30 p.m. Cross Reference: N0386 DHS 83.35(3)(a)2 Comprehensive Individual Service Plan	N 612		