STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020168	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING PROOF FAMILY FACILITY 2	3600 N 58TH BLVD MILWAUKEE, WI 53216

(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 04/23/2025, Surveyor completed a complaint investigation at Living Proof Family Facility 2. As a result, 3 deficiencies were identified. One complaint was unsubstantiated. Census: 2	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review, observation, and interview the provider did not ensure 1 of 1 incident was reported to the Department for Resident 1, when there was significant change in a resident's status. Resident 1 fractured her/his left foot, was hospitalized, and sent back to the facility with a postop shoe. The provider did not report the incident to the Department. Findings include: The facility was licensed as an ambulatory adult family home (AFH), serving up to 3 residents in client groups irreversible dementia/Alzheimer's, traumatic brain injury, advanced age,	M 134		

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
	0020168	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING PROOF FAMILY FACILITY 2	3600 N 58TH BLVD MILWAUKEE, WI 53216

(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 134	Continued From page 1 developmentally disabled, emotionally disturbed/mental illness, public funding, alcohol/drug dependent, and terminally ill. On 04/22/2025, Surveyor reviewed Department records. Surveyor did not locate evidence the provider submitted any self-reports in 2025. On 04/23/2025, at 9:12 AM, Surveyor interviewed Resident 1. Surveyor observed Resident 1's left foot was swollen, and s/he was wearing a medical shoe. There were 2 walkers inside Resident 1's room. Surveyor inquired what happened and Resident 1 stated the following: S/He fell and became dizzy, and her/his left foot was hurting her/him. S/He did not know when, where, or how s/he fell. S/He was unable to get up from the floor on her own when she fell and reported staff helped her/him up. S/He told staff her/his foot was in pain, and they took her to the doctor. S/He felt s/he had received medical care within a timely manner. S/He had a follow-up appointment with her/his doctor setup for the following week. On 04/23/2025, at 9:21 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/04/2022. The facility progress notes documented on 03/02/2025, at 9:30 AM, Resident 1 complained of foot pain and was sent to the hospital. Hospital discharge paperwork documented Resident 1 was admitted to the hospital on 04/02/2025 and diagnosed with fractures to her/his left foot. S/He was discharged from the hospital on 04/03/2025. Horizon Home Care was setup by the hospital to provide physical (PT) and occupational therapy (OT) in the AFH to Resident 1. No other follow-up was recommended by the hospital.	M 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020168	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING PROOF FAMILY FACILITY 2	3600 N 58TH BLVD MILWAUKEE, WI 53216

(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 134	Continued From page 2 On 04/23/2025 during survey, from approximately 9:20 AM through 10:50 AM, Surveyor observed Resident 1 using a walker and the help of the caregivers to move around the house. At 10:50 AM, Physical Therapist (PT) E was working with Resident 1, while s/he utilized the walker for assistance. On 04/23/2025, at 10:46 AM, Surveyor interviewed Caregiver/House Manager (C/HM) A. Surveyor inquired about the progress notes, specifically from 03/02/2025. C/HM A reported the date on the progress notes was wrong and it should have been 04/02/2025. Caregiver B was working on 04/02/2025 and confirmed it had been documented as the incorrect date. C/HM A reported as soon as Resident 1's foot swelled up and started to change color the following day, s/he was sent to the hospital. Following Resident 1's return from the hospital, the facility completed weekly body checks for Resident 1. OT and PT have come to the facility on a once weekly basis since Resident 1 had been discharged from the hospital. Resident 1 walks with a walker and a medical shoe and requires standby assistance. C/HM A reported Licensee C was responsible for filing self-reports with the Department, but C/HM A helped with paperwork. C/HM A stated, "we didn't know to self-report. We thought if we reported it to the case manager that's all we needed to do." C/HM A reported Licensee C called Guardian D within 2 hours of Resident 1 having been admitted to the hospital. C/HM A showed Surveyor an email from 04/03/2025, at 1:34 PM, in which the hospital admission was reported to Resident 1's case manager and registered nurse.	M 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020168	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING PROOF FAMILY FACILITY 2	3600 N 58TH BLVD MILWAUKEE, WI 53216

(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 262	Continued From page 3	M 262		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 2 exits from the home were ramped to grade with a hard surfaced pathway with handrails for residents who walk only with difficulty, or only with the assistance of crutches, a cane, or a walker, or are unable to easily negotiate stairs without assistance. Resident 1 utilized a walker for ambulation. Findings include: The facility was licensed on 10/21/2024, to serve up to 3 ambulatory residents.	M 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020168	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING PROOF FAMILY FACILITY 2	3600 N 58TH BLVD MILWAUKEE, WI 53216

(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 262	Continued From page 4 On 04/23/2025, at 9:00 AM, Surveyor conducted a tour of the facility and observed the following: - The front entry door, identified as an emergency exit, had 4 steps to enter the residence. - The side exit door was identified as an emergency exit. The side exit led to a stairwell with 3 steps to the landing. Once on the landing, Surveyor exited through the side door and down 1 step. The side exit had a total of 4 steps and 2 doors to exit the facility. - Resident 1 was observed using a walker for ambulation. S/He also had a postop shoe on her/his left foot. - Surveyor observed a second walker with a fold down seat in Resident 1's bedroom. Resident 1 did not share her/his bedroom with anyone. On 04/23/2025, at 9:21 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/04/2022 with diagnoses including anemia, unspecified anxiety disorder, unspecified displaced tri malleolar fracture of lower leg, sequela other malaise, and unspecified intellectual disabilities. Resident 1's individual service plan (ISP), dated 01/26/2025, indicated Resident 1 required the use of a walker for ambulation and needed assistance transferring and walking through the facility. On 04/23/2025, at 10:32 AM, Surveyor interviewed Caregiver/House Manager (C/HM) A. C/HM A reported the walker Resident 1 was using was the facility's walker and s/he did not require it. Surveyor inquired about Resident 1's ISP, where it indicated Resident 1 required the use of	M 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020168	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING PROOF FAMILY FACILITY 2	3600 N 58TH BLVD MILWAUKEE, WI 53216

(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 262	Continued From page 5 a walker and assistance walking through the facility. C/HM reported s/he did not know why that information was on Resident 1's ISP. On 04/23/2025, at 10:50 AM, Physical Therapist (PT) E arrived for Resident 1's physical therapy appointment. Surveyor observed PT E working with Resident 1 and observed her/him ambulating with a walker through the dining room and living room. PT E and staff were rearranging living room furniture to accommodate Resident 1 walking through with the walker. Surveyor interviewed PT E and inquired what s/he knew about Resident 1's ambulation prior to the injury of her/his left foot. PT E was unaware of Resident 1's ambulation status prior to her/his admission to physical therapy on 04/07/2025.	M 262		
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.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020168	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING PROOF FAMILY FACILITY 2	3600 N 58TH BLVD MILWAUKEE, WI 53216

(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 424	Continued From page 6	M 424		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a resident's individual service plan (ISP) was reviewed when there was a change for 1 of 1 resident (Resident 1). Resident 1 suffered fractures to her/his left foot, and her/his ISP was not reviewed and updated to reflect the changes.

Findings include:

On 04/23/2025, at 9:21 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/04/2022 with diagnoses including anemia, unspecified anxiety disorder, unspecified displaced trimalleolar fracture of lower leg, sequela other malaise, and unspecified intellectual disabilities. Progress notes indicated Resident 1 was complaining of pain in her/his left foot and it was swollen. Resident 1 was taken to the hospital on 04/02/2025, where s/he was admitted.

Surveyor reviewed an after-visit summary (AVS) and a hospital discharge summary. The documents indicated Resident 1 had a left foot fracture and was given a postop shoe. The documents indicated Resident 1 was to follow up with Horizon Home Care physical (PT) and occupational therapy (OT). Resident 1 began in home PT and OT on 04/07/2025.

Resident 1's ISP, dated 01/26/2025, was not updated to reflect Resident 1's change of condition. Resident 1's ISP did not contain information regarding the postop shoe or PT and OT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020168	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING PROOF FAMILY FACILITY 2	**3600 N 58TH BLVD MILWAUKEE, WI 53216**

(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 424	Continued From page 7 On 04/23/2025, at 10:32 AM, Surveyor interviewed Caregiver/House Manager (C/HM) A. C/HM A reported Resident 1's ISP was not updated upon return from the hospital. C/HM A stated, "we know we need to." S/He did not offer an explanation why Resident 1's ISP was not updated. C/HM A reported s/he would speak with Licensee C to get Resident 1's ISP updated immediately.	M 424		