STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019288	A. BUILDING: _____ B. WING _____	R-C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGEL HOME 2 LLC	2110 HARRIET ST RACINE, WI 53404

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{M 000}	INITIAL COMMENTS On 05/07/2024 with information gathered through 05/08/2024, Surveyor conducted a standard survey, three complaint investigations and a verification visit. Eleven deficiencies identified. Four are repeat deficiencies from SOD 0BDD11 dated 05/10/2023. Three of three complaints unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{M 000}		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure the gas furnace was inspected by a heating contractor of local utility company at least every 3 years for 1 of 1 furnace.. Findings include: On 05/07/2024, Surveyor requested to review facility's most recent furnace inspection. Licensee A could not locate a furnace inspection. On 05/07/2024 at 11:00 AM, Surveyor interviewed Licensee A. Licensee A stated s/he was aware of the required 3-year furnace inspection.	M 290		

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

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M 332	Continued From page 1	M 332		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a fire extinguisher on each floor of the facility for 1 of 3 floors. There was no fire extinguisher for the upstairs where all resident's resided. Findings include: On 05/07/2024 at approximately 09:15 AM, Surveyor conducted an onsite tour. Surveyor observed fire extinguishers in the kitchen and	M 332		

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M 332	Continued From page 2 basement. Surveyor could not locate a fire extinguisher for the upstairs. Surveyor asked Caregiver B where the fire extinguisher was located, and Caregiver B stated there was not one up there because it fell down. On 05/07/2024, at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A stated there should have been a fire extinguisher upstairs and the staff should have replaced it when it fell down.	M 332		
{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 1 of 7 required locations. The smoke detector at the bottom of the staircase had no battery in it.	{M 334}		

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{M 334}	Continued From page 3 This is a repeat deficiency. See Statement of Deficiency (SOD) 0BDD11, dated 05/10/2023. Findings include: On 05/07/2024, at 9:30 AM, Surveyor toured the home and observed the following: -The smoke detector at the bottom of the staircase was not working because there was no battery in it. On 05/07/2024 at 10:15 AM, Surveyor interviewed Licensee A. Licensee A asked Caregiver B why there was no battery in the smoke detector. Caregiver B stated the battery had died and s/he needed to replace it and forgot to grab one this morning and put it in the smoke detector.	{M 334}		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each required smoke detector was tested monthly to make sure that the smoke detector was operating for 1 of 1	M 336		

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M 336	Continued From page 4 calendar year reviewed (2023). Findings include: On 05/07/2024 at approximately 10:00 AM, Surveyor requested documentation of the home's smoke detector tests from Licensee A. Licensee A provided Surveyor with a binder where smoke detector tests were documented. Surveyor did not see any smoke detector tests documentation for calendar year 2023. On 05/07/2024 at approximately 10:15 AM, Surveyor interviewed Licensee A. Licensee A stated the monthly checks should have been in the binder so s/he was not sure why they were not done.	M 336		
M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a record of semi-annual fire drills conducted with all household members for 1 of 1 year. The provider had no fire drills completed for calendar year 2023. Findings include: On 05/07/2024 at approximately 10:00 AM, Surveyor requested to review fire drills for calendar year 2023. There was no evidence of any fire drills conducted in calendar year 2023.	M 348		

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M 348	Continued From page 5 On 05/07/2024, at approximately 10:15 AM, Surveyor interviewed Licensee A about fire drills. Licensee A stated the fire drills should have been in the state binder but s/he could not locate any of the fire drills for 2023. Cross Reference 0332 DHS 88.05(4)(b) Fire Safety-Fire Extinguishers Cross Reference 0334 DHS 88.5(4)(b)1 Fire Safety-Smoke Detectors Cross Reference 0336 DHS 88.5(4)(b)2 Smoke Detectors-Testing and Maintenance	M 348		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 8) reviewed had a service agreement completed prior to admission that was signed. Findings include:	M 384		

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M 384	Continued From page 6 On 05/07/2024, Surveyor reviewed Resident 8's record and identified the following: -Resident 8 was admitted to the provider on 08/22/2023. Resident 8's record did not contain evidence of a service agreement. On 05/07/2024 at 10:00 AM, Surveyor interviewed Licensee A. Licensee A stated s/he thought one was filled out but Resident 8 must not have signed it. Surveyor asked Licensee A if Resident 8 was his/her own decision maker, and Licensee A stated, "yes."	M 384		
M 402	88.06(2)(c)8 RESIDENT RIGHTS AND GRIEVANCE A statement indicating that the resident rights and grievance procedures have been explained and copies provided to the resident and the resident's guardian or designated representative, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 8) admitted to the home had a statement indicating resident rights and grievance procedures had been explained and copies provided to the resident and resident's guardian or designated representative, if any. Findings include: On 05/07/2024, Surveyor reviewed Resident 8's record and identified the following: -Resident 8 was admitted to the provider on	M 402		

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M 402	Continued From page 7 08/22/2023. Resident 8's record did not contain evidence of resident rights and grievance procedures explained with resident and/or resident's guardian. On 05/07/2024 at 10:00 AM, Surveyor interviewed Licensee A. Licensee A stated s/he thought one was filled out but Resident 8 must not have signed it. Surveyor asked Licensee A if Resident 8 was his/her own decision maker and Licensee A stated, "yes."	M 402		
{M 404}	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an individual service plan (ISP) was completed for 1 of 1 resident. Resident 7 was admitted on 07/06/2023 and was due to have an ISP completed and developed within 30 days. This is a repeat deficiency. See Statement of Deficiency (SOD) 0BDD11, dated 05/10/2024. Findings include: On 05/07/2024, at 9:00 AM, Surveyor reviewed resident records and identified the following:	{M 404}		

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{M 404}	Continued From page 8 Resident 7 was admitted on 07/06/2023. Resident 7's record did not contain an ISP. On 05/07/2024, at 11:00 AM, Surveyor interviewed Licensee A regarding the ISPs. Licensee A confirmed Resident 7 did not have an ISP completed within 30 days of admission. Licensee A stated s/he would make sure moving forward all residents in the home had an ISP upon admission.	{M 404}		
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 record review and interview, the provider did not update the Individual Service Plan (ISP) every 6 months for 1 of 1 resident	M 424		

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M 424	Continued From page 9 (Resident 8). Resident 8's ISP was due to be reviewed for an update in 03/2024 and was not reviewed or updated. Findings include: On 05/07/2024 at approximately 10:00 AM, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's home on 08/22/2023 and was his/her own person. Resident 8's current ISP was dated for 09/12/2023 and had no signature. On 05/07/2024 at approximately 10:30 AM, Surveyor interviewed Licensee A. Licensee A stated s/he was aware that ISPs needed to be reviewed and updated every 6 months. Licensee A stated s/he was not sure why Resident 8s ISP did not get updated.	M 424		
{M 458}	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation, record review, and	{M 458}		

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{M 458}	Continued From page 10 interview, the provider did not ensure prescription medications were securely stored for 1 of 1 resident. Resident 2's insulin was in the lockbox in the refrigerator and it was not locked. This is a repeat deficiency. See Statement of Deficiency (SOD) 0BDD11, dated 05/10/2024. Findings include: On 05/07/2024, at 9:30 AM, Surveyor toured the facility. Surveyor observed a black lockbox in the refrigerator. Surveyor asked House Lead G if someone received insulin. House Lead G stated Resident 6 received insulin. Surveyor asked House Lead G to open the lockbox. House Lead G opened the lockbox. The lockbox had three insulin pens in there. Surveyor asked if the lockbox should have been locked. House Lead G stated, "yes it should be," and took the lockbox out of the refrigerator and handed it to Coordinator H. Coordinator H put in a code and showed Surveyor that the box was locked now. Residents was observed ambulating throughout the facility. On 05/07/2023, at 9:45 AM, Surveyor interviewed Licensee A. Licensee A stated the box should have been locked at all times.	{M 458}		
{M 464}	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying	{M 464}		

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{M 464}	Continued From page 11 who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician who prescribed the medication specifying who by name or position was permitted to administer the medication, under what circumstances, and in what dosage the medication was to be administered for 1 of 4 residents. Resident 3 required staff of the adult family home to administer medication and there were no physician's orders in the record. This is a repeat deficiency. See Statement of Deficiency (SOD) 0BDD11, dated 05/10/2023. Findings include: On 05/07/2024, at 10:30 AM, Surveyor reviewed resident records and identified the following: Resident 3 was admitted on 04/07/2023. Resident 3's record contained a MAR 05/2024, which indicated staff administered medications. Resident 3's record contained a written order that was signed off by his/her physician's Certified Medical Assistant (CMA) and not the physician prescribing the medications. On 05/07/2024, at 10:15 AM, Surveyor interviewed Coordinator H. Coordinator H confirmed Resident 3 required assistance with medication administration from staff.	{M 464}		

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{M 464}	Continued From page 12 On 05/07/2024, at 10:30 AM, Surveyor interviewed Licensee A regarding the required written order to administer medications. Licensee A and Coordinator H stated they were not aware that it had to be a physician to sign off on the orders. Licensee A stated s/he would have Resident 3's physician sign off on his/her medications immediately.	{M 464}		