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 08/14/2025

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

(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 08/13/2025 with information gathered through 08/14/2025, Surveyor conducted a complaint investigation and verification visit for SOD 0BDD13, dated 10/04/2024, at Guardian Angel Homes 2 LLC, an Adult Family Home (AFH) in Racine, WI. Seven deficiencies were identified. Three of the 7 deficiencies are repeat deficiencies from Statement of Deficiency (SOD) 0BDD11, dated 05/10/2023, SOD 0BDD12, dated 05/08/2024, and SOD 0BDD13, dated 10/04/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Complaint unsubstantiated. 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 observation, record review, and interviews, the provider did not ensure the home and its operation complied with this chapter and all other laws governing the home and its operations potentially affecting 4 of 4 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations. At the time of this verification visit, the provider had 3repeat violations. The provider	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		

did not follow Special Orders which resulted from previous Statement of Deficiency (SOD) J6S712, dated 01/27/2022, and SOD 76S713, dated 05/26/2023.

Findings include:

On 08/13/2025, Surveyor reviewed Department records and identified on 12/10/2024, SOD 0BDD13 and a Special Orders Letter were issued to Licensee A via email with the following:

"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 Guardian Angel Homes 2:

1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., the licensee shall develop and implement corrective measures to ensure all service providers protect and promote each resident's right to live in a home that is safe, clean, and well-maintained.

WITHIN 45 DAYS of receipt of this notice, the licensee will provide training to all service providers on the corrective actions taken to resolve each environmental deficiency identified in Statement of Deficiency 0BDD13. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training."

On 08/13/2025 with information gathered through 08/14/2025, Surveyor conducted a complaint investigation, and verification visit for SOD

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M 216	Continued From page 2 0BDD13, dated 10/04/2024, at Guardian Angel Homes 2 LLC. As a result of the survey, the provider was issued 7 deficiencies. Three of the 7 were repeat deficiencies. The following 7 deficiencies, which includes this violation, were identified: M 216 88.04(2)(a) - Responsibilities M 276 88.05(3)(a) - Home Environment M 332 88.05(4)(a) - Fire Safety - Fire Extinguishers (repeat) M 334 88.05(4)(b)1 - Fire Safety - Smoke Detectors (repeat) M 346 88.05(4)(d)2.b - Fire Evacuation Annual Evaluation M 420 88.06(3)(d)5 - Signed Statement Of Agreement M 424 88.06(3)(f) - Review Of Isp (repeat) On 08/13/2025, at approximately 9:34 AM, Surveyor interviewed Licensee A and confirmed receipt of SOD 0BDD13 and the Notice and Order Letter. Licensee A stated s/he would email Surveyor the documentation that s/he provided training to all staff on the corrective actions taken to resolve each environmental deficiency identified in Statement of Deficiency 0BDD13 by 1:00 PM. As of 08/14/2025, Surveyor did not receive evidence that Licensee A provided training to all staff on the corrective actions taken to resolve each environmental deficiency identified in Statement of Deficiency 0BDD13.	M 216		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall	M 276		

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M 276	Continued From page 3 provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a clean, well-maintained and homelike environment for 2 of 2 residents (Resident 3 and Resident 6) in the home. The home required cleaning and repairs. Findings include: On 08/13/2025, at approximately 10:54 AM, Surveyor toured the facility with Licensee A and observed the following: -1 rodent trap in the right corner in dining room. -Second floor hallway light switch wall plate was missing. -Second floor hallway walls contained numerous holes and cracks. -Resident 3's room door had a hole and missing door knob. -Resident 3's room door was dirty and had wood peeling from door. -Resident 6's room door knob was loose. On 08/13/2025, at approximately 10:54 AM, Surveyor interviewed Licensee A. Licensee A	M 276		

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M 276	Continued From page 4 confirmed the home environment issues throughout facility.	M 276		
{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 2 of 3 floors. There was no fire extinguisher for the second floor where all residents resided and in the basement by an authorized dealer or the local fire department. The provider also did not ensure 2 of 2 fire extinguishers were annually inspected. The	{M 332}		

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{M 332}	Continued From page 5 2 fire extinguishers located near the kitchen, were last inspected October 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 0BDD12, dated 05/08/2024 and 0BDD13, dated 10/04/2024. Findings include: On 08/13/2025, at approximately 10:54 AM, Surveyor toured the facility with Licensee A and observed the following: -Vacant mount for fire extinguisher on the second floor. -There was no fire extinguisher in the basement. -Fire extinguisher located near the kitchen was last inspected October 2023. -Fire extinguisher located on the kitchen countertop was last inspected October 2023. On 08/13/2025, at approximately 10:54 AM, Surveyor interviewed Licensee A. Licensee A stated s/he did not know why staff removed the fire extinguisher from the second floor. Licensee A confirmed the basement did not have a fire extinguisher. Licensee A confirmed the inspection tags read October 2023. Licensee A reported s/he assumed the maintenance person took fire extinguishers to be inspected and tagged.	{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	{M 334}		

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{M 334}	Continued From page 6 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. There was no smoke detector in the dining room. This is a repeat deficiency. See Statement of Deficiency (SOD) 0BDD11, dated 05/10/2023, SOD 0BDD12, dated 05/08/2024, and SOD 0BDD13, dated 10/04/2024. Findings include: On 08/13/2025, at approximately 10:54 AM, Surveyor toured the facility with Licensee A and observed the following: -There was no smoke detector in the dining room. On 08/13/2025, at approximately 10:54 AM, Surveyor interviewed Licensee A. Licensee A confirmed there was no smoke detector in the dining room. Licensee A reported s/he did not know what happened to the smoke detector.	{M 334}		

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M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents' (Resident 3 and Resident 6) reviewed were evaluated annually for evacuation time, using the Department's form. Resident 3 had not been evaluated for evacuation for calendar years 2024 and to date in 2025 using the Department's form. Resident 6 had not been evaluated for evacuation for calendar years 2023, 2024, and to date in 2025 using the Department's form. Findings include: The facility is licensed to provide services for up to 4 residents with client groups of emotionally disturbed/mental illness, traumatic brain injury, correctional clients, advanced aged, and developmentally disabled. On 08/13/2025, Surveyor reviewed residents' records and identified the following: -Resident 3 was admitted to the provider's home on 04/07/2023. Resident 3's record did not contain evidence of an evacuation assessment for calendar year 2024 and to date in 2025 using the Department's form.	M 346		

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M 346	Continued From page 8 -Resident 6 was admitted to the provider's home on 04/12/2022. Resident 6's record did not contain evidence of an evacuation assessment for calendar years 2023, 2024, and to date in 2025 using the Department's form. On 08/13/2025, at approximately 9:34 AM, Surveyor interviewed Licensee A. Licensee A confirmed s/he did not have annual evacuation assessments for residents. Licensee A stated s/he was not aware of this requirement.	M 346		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents' (Resident 3 and Resident 6) individual service plans (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 3's and Resident 6's ISPs did not include a signed statement of agreement with all parties involved. Findings include: On 08/13//2025, Surveyor reviewed residents' records and identified the following: -Resident 3 was admitted to the provider's home	M 420		

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M 420	Continued From page 9 on 04/07/2023. -Resident 3 had a legal guardian. -Resident 3's ISP, dated 12/11/2024, was not signed by his/her guardian. -Resident 6 was admitted to the provider's home on 04/12/2022. -Resident 6 had a legal guardian. -Resident 6's ISP, dated 07/11/2025, was not signed by his/her guardian. On 08/13/2025, at approximately 9:34 AM, Surveyor interviewed Licensee A. Licensee A confirmed residents' ISPs did not include a signed statement of agreement with all parties involved. Licensee A stated s/he did not know DHS (Department of Health Services) Chapter 88 regulations.	M 420		
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		

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M 424	Continued From page 10	M 424		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 2 residents (Resident 3) reviewed had his/her individual service plan (ISP) reviewed every 6 months to determine continued appropriateness of the plan and to update the plan as necessary.

This is a repeat deficiency. See Statement of Deficiency 0BDD12, dated 05/08/2024.

Findings include:

On 08/13/2025, Surveyor reviewed Resident 3's record and identified the following:

-Resident 3 was admitted to the provider's home on 04/07/2023.
-Resident 3 had a legal guardian.
-There was no evidence Resident 3's ISP was reviewed and updated after 12/11/2024. At minimum, Resident 3's ISP should have been reviewed and updated in June 2025.

On 08/13/2025, at approximately 9:34 AM, Surveyor interviewed Licensee A. Licensee A stated s/he would email Resident 3's most recent ISP to Surveyor by 5:00 PM.

As of 08/14/2025, Surveyor did not receive evidence of Resident 3's most recent ISP.