STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017982	A. BUILDING: _____ B. WING _____	R-C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE AT HOME	**2301 WILLIAM STREET 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 08/27/2024, Surveyors conducted a verification visit, complaint investigation and a standard survey at Good Life at Home, an Adult Family Home (AFH) in Racine, WI. Three deficiencies identified. One of 3 deficiencies is a repeat deficiency. Complaint unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 2	{M 000}		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the home had at least 2 means of exiting which provided unobstructed access to the outside for 2 of 2 exits. The provider's exits were obstructed with maglocks. Findings include: On 08/27/2024 at approximately 11:00 AM, Surveyors toured the provider's home. The following concerns were identified:	M 338		

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

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M 338	Continued From page 1 - Two of two exit doors were obstructed with maglocks. On 08/27/2024 at approximately 2:00 PM, Surveyors reviewed department records and was unable to locate a waiver. On 08/27/2024, Surveyors reviewed Resident 6's record and identified the following: - Resident 6 was admitted to the provider's home on 07/30/2024. Resident 6's magnetic lock protocol stated s/he was at high risk for elopement and required a magnetic locking system for safety. On 08/27/2024 at 2:49 PM, Surveyors interviewed Regional Manager I regarding the home's maglocks. Regional Manager I stated the home did not have a waiver for mag locks on file. Regional Manager I stated the maglocks were in place to provide safety for Resident 6 due to his/her high risk for elopement.	M 338		
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.	M 348		

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M 348	Continued From page 2 Findings include: On 08/27/2024 at approximately 10:00 AM, Surveyors requested to review fire drills for calendar year 2023. There was no evidence of any fire drills conducted in calendar year 2023. On 08/27/2024 at approximately 10:15 AM, Surveyors interviewed Regional Manager I about fire drills. Regional Manager I stated fire drills for calendar year 2023 would be sent via e-mail. As of 08/27/2024 at 4:00 PM, Surveyors did not receive evidence of semi-annual fire drills for calendar year 2023.	M 348		
{M 406}	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Behavior Support Plan (BSP) and Individual Service Plan (ISP) for 1 of 2 residents (Resident 5) reviewed were developed with the resident's legal guardian.	{M 406}		

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{M 406}	Continued From page 3 This is a repeat deficiency. See Statement of Deficiency (SOD) ONUY11, dated 11/02/2021 and SOD ONUY12, dated 02/24/2022. Findings include: On 08/27/2024 at approximately 9:30 AM, Surveyors reviewed Resident 5's record. Resident 5 was admitted to the provider's home on 06/01/2023. Resident 5 was enrolled in a managed care organization. Resident 5 had a corporate legal guardian. Resident 5's BSP, dated 07/19/2024, and ISP, dated 12/19/2023, were not signed by his/her legal guardian. On 08/27/2024 at approximately 12:20 PM, Surveyors interviewed Licensee A. Licensee A acknowledged Resident 5's legal guardian did not sign his/her BSP and ISP. Licensee A would ensure Resident 5's legal guardian assisted in creating the BSP and ISP. Licensee A reported s/he would ensure legal guardian signed and received a copy of the BSP and ISP.	{M 406}		