STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	**3525 NORTH 20TH STREET MILWAUKEE, WI 53206**

(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 Surveyor: Crawford, Devin M. On 08/21/2025, Surveyors completed a verification visit and complaint investigation at Living Insight Adult Family Home. As a result, 4 previous deficiencies were corrected, 2 deficiencies were recited, and 7 new deficiencies were identified, for a total of 9 deficiencies. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. 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 record review and interview, the licensee did not ensure the home, and its operation complied with this chapter and with all other laws governing the home and its operation. The provider was unable to maintain substantial compliance and had 2 repeat violations. The provider admitted a respite resident who stayed beyond 14 days and the provider did not complete required documents upon the respite ending and the resident staying in the facility. Findings include: Example 1	M 216		

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
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 216	Continued From page 1 On 08/21/2025, Surveyors concluded a complaint investigation and verification visit. As a result of the survey, the provider was issued 9 deficiencies. Two of 9 were repeat deficiencies. 88.04(2)(a) - Responsibilities 88.05(4)(d)2a - Fire Evacuation Plan Review 88.06(2)(a) - Admission-Health Exam 88.06(2)(b) - Service Agreement Except Respite 88.06(3)(d)5 - Signed Statement of Agreement - repeat 88.07(3)(a) - Prescription Medication - repeat 88.07(3)(d) - Medication Written Order 88.09(1)(e) - Resident's Record Retention 88.10(3)(e) - Self-Direction Example 2 The facility was licensed to serve 3 non-ambulatory residents in the client groups of developmentally disabled, alcohol/drug dependent, correctional clients, advanced aged, physically disabled, irreversible dementia/Alzheimer's, traumatic brain injury, emotionally disturbed/mental illness and terminally ill. According to Wis. Admin. Code § DHS 88.02(30) "Respite care" means temporary placement in an adult family home for maintenance of care, treatment or services, as established by the agency or individual responsible for planning, arranging or providing services to the individual, in addition to room and board, for no more than 14 consecutive days at a time. On 07/21/2025, at 11:39 AM, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 02/28/2025 with diagnoses including quadriplegia. Resident 4's record	M 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 216	Continued From page 2 contained an individual service plan (ISP) and after visit summaries (AVS) from emergency room (ER) visits. Surveyor reviewed emails which were included in Resident 4's record by Licensee A. - 02/24/2025 at 4:20 PM - Email from House Manager B to Case Manager D. " ...to help [her/his] transition move smoothly and quickly we can take [her/him] right away under a respite stay, If [s/he] wants to stay with us permanently [sic] which as of right now sounds like [s/he] does, then we can get the items we would generally need prior to placement in order at that time ..." - 04/01/2025 at 10:13 AM - Email from adult family home (AFH) to Case Manager D. "Good morning, the authorization for respited ended 3/28/25. Can you update it? Have you spoken to [her/him] about [her/his] plans? Let us know what the plan is moving forward." 04/03/2025 at 8:56 AM - Email from Case Manager D to AFH. " ...The respite auth [sic] has been extended. Member has been in frequent contact with both muself [sic] and my supervisor and is aware we are waiting form [sic] the provider [s/he] is moving to ...but I extended the respite until the 15th for now." - 04/03/2025 at 9:31 AM - Email from AFH to Case Manager D. "Thank you for the update. So [s/he] does plan on moving elsewhere?" 04/18/2025 at 2:09 PM - Email from AFH to Case Manager D." ...We see you extended the respite stay for another 30 days. We do have a member looking to move in permanently in May and are looking for a set day. Is it safe to give them 5/20	M 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 216	Continued From page 3 as a move in date?..." 05/01/2025 at 11:40 AM - Email from AFH to Case Manager D. " ...I'm looking for an update on [Resident 4] ....[her/his] respite stay has already been extended twice and we've discussed that we had a placement that was awaiting that room. We just went into MIDAS (managed care provider portal) and saw that [her/his] authorization was changed from respite to residential through October 31st without our knowledge. [Resident 4] staying permanently was never discussed or put in place and [Resident 4] is still under the impression [s/he] is moving out ..." 05/08/2025 at 4:33 PM - Email from AFH to Case Manager D. " ...This is a text that [Resident 4] sent me. [S/He] is very adamant about leaving ...I want you to give me a 30-day notice ...Can you please give me a 30-day notice so they could get me out of here [sic] soon as possible [sic]" 05/09/2025 at 9:29 AM - Email from Case Manager D to AFH. " ...I am not sure what [s/he] thinks a 30 day will accomplish since we are already in process of getting new placement, and we will try to talk to [her/him]. I hope we can resolve all this soon for everyone ..." 06/02/2025 at 12:15 PM - Email from AFH to Case Manager D. " ...We've attached a 30-day notice for [Resident 4] ....it's not fair to us to receive no type of communication when we've been reaching out for updates on what was supposed to be just a respite stay. Hopefully this will get us some type of response as to what the plan is and to what's being done for [her/his] relocation." On 07/21/2025, at 2:10 PM, Surveyors	M 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 216	Continued From page 4 interviewed Licensee A. Licensee A reported s/he thought respite stays were 28 days. Licensee A reported Resident 4's managed care organization (MCO) was unable to find placement for Resident 4 which is why the respite was extended numerous times.	M 216		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident was evaluated for fire evacuation to determine whether the resident was able to evacuate the home without any assistance within 2 minutes. Resident 4 was not evaluated for fire evacuation. Findings include: On 07/21/2025, at 9:50 AM, Surveyors reviewed Resident 4's record. Resident 4 was admitted on 02/28/2025, with a diagnosis of quadriplegia. Resident 4's record did not contain evidence Resident 4 was evaluated for fire evacuation. On 07/21/2025, at 2:10 PM, Surveyors interviewed Licensee A. Licensee A confirmed the	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 344	Continued From page 5 code requirement. Licensee A reported Resident 4 was admitted as a respite resident and s/he did not complete the evacuation assessment for Resident 4. Licensee A acknowledged Resident 4 should have had an evacuation assessment completed.	M 344		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident was screened for communicable diseases, including tuberculosis (TB). Resident 4 was not screened for communicable diseases, including TB, within 90 days prior to admission or 7 days after admission. Findings include: On 07/21/2025, at 9:50 AM, Surveyors reviewed Resident 4's record. Resident 4 was admitted on 02/28/2025, with a diagnosis of quadriplegia.	M 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 380	Continued From page 6 Resident 4's record did not contain evidence Resident 4 was screened for TB or communicable diseases. On 07/21/2025, at 2:10 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A confirmed Resident 4 was not screened for TB or communicable diseases prior to or within 7 days after admission to the facility because s/he was a respite resident. Surveyors reviewed code requirement with Licensee A for residents to be screened for communicable disease, including TB, within 90 days prior to admission or 7 days after admission for residents.	M 380		
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 an admission agreement was completed, dated, and signed by each resident, guardian or designated representative, and licensee, prior to admission for 1 of 1	M 384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 384	Continued From page 7 resident (Resident 4). Resident 4 did not have signed admission agreement. Findings include: On 07/21/2025, at 9:50 AM, Surveyors reviewed Resident 4's record. Resident 4 was admitted on 02/28/2025 for a respite stay, with a diagnosis of quadriplegia. Resident 4's record indicated s/he was her/his own person. Resident 4's record did not contain any evidence of a signed agreement between the licensee and Resident 4. Surveyors reviewed a document titled 30-day discharge notice, dated 06/02/2025. The 30-day discharge notice indicated a discharge date of 07/01/2025, 124 days after Resident 4's admission to the facility. On 07/21/2025, at 2:10 PM, Surveyors interviewed Licensee A. Licensee A reported s/he believed respite stay was up to 28 days. Licensee A reported s/he did not have a signed agreement for Resident 4. Licensee A reported Resident 4 was an emergency admit for a respite stay. Licensee A reported Resident 4's Managed Care Organization (MCO) extended Resident 4's respite stay two times. Surveyors informed Licensee A of respite stay limitation of 14 consecutive days.	M 384		
{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.	{M 420}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 420}	Continued From page 8	{M 420}		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a statement of agreement with the individual service plan (ISP) was dated and signed by all persons involved in developing the plan for 2 of 2 residents (Resident 3 and Resident 4). Resident 3's ISP was not signed by her/his guardian. Resident 4's ISP was not signed by her/his managed care organization (MCO).

This is a repeat deficiency. See Statement of Deficiency (SOD) E66U11, dated 01/27/2025.

Findings include:

On 07/21/2025, at 9:50 AM, Surveyors reviewed Resident 3's record. Resident 3 was admitted on 01/22/2024 with diagnoses including asthma, chronic obstructive
pulmonary disease, and malnutrition. Resident 3 had a guardian. Resident 3's ISP was
dated 01/23/2025. Resident 3's ISP was signed by House Manager B, Resident 3's MCO care management team, and Resident 3. Resident 3's ISP was not signed Resident 3's guardian.

Resident 4 was admitted on 02/28/2025, with a diagnosis of quadriplegia. Resident 4 was her/his own person. Resident 4's ISP was dated 02/28/2025. Resident 4's ISP was signed by Licensee A. Resident 4 was unable to sign her/his ISP due to her/his diagnosis of quadriplegia. Resident 4's ISP was not signed by her/his MCO care management team.

On 08/21/2025, at 12:15 PM, Surveyor interviewed Licensee A and House Manager B. Licensee A and House Manager B confirmed the code requirement. Licensee A and House

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 420}	Continued From page 9 Manager B reported Resident 3's guardian sent an email to Resident 3's MCO about not being Resident 3's guardian anymore. Licensee A and House Manager B reported they were unsure of what the status of the guardianship was, but as far as they knew, Resident 3 still had the same guardian. Licensee A and House Manager B did not offer any information regarding Resident 4.	{M 420}		
{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 and interview, the provider did not ensure 1 of 1 resident (Resident 1's) prescription medications were securely stored. Resident 1's insulin pens were not securely stored in the kitchen refrigerator. This is a repeat deficiency. See Statement of Deficiency (SOD) E66U11, dated 01/27/2025. Findings include: On 07/21/2025, at 10:11 AM, Surveyors toured	{M 458}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 458}	Continued From page 10 the kitchen. Surveyors observed a lock box in the refrigerator. The lock box contained a locking mechanism, which was not engaged. The lock box contained 7 Lantus insulin pens, and 2 Humalog pens. Surveyors observed residents moving freely around the facility. On 08/21/2025, at 12:15 PM, Surveyor interviewed Licensee A and House Manager B. Licensee A and House Manager B confirmed the code requirement. Licensee A reported staff were to dispose of the insulin pens. Licensee A reported s/he and House Manager B needed to ensure they followed up with staff, as staff was to take care of the medications after the last survey.	{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 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 medications to the	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 464	Continued From page 11 resident, stating who can administer the medications for 1 of 1 resident. Resident 4's record did not contain a written order to administer medications. Findings include: On 07/21/2025, at 9:50 AM, Surveyors reviewed Resident 4's record. Resident 4 was admitted on 02/28/2025, with a diagnosis of quadriplegia. Resident 4's individual service plan (ISP), dated 02/28/2025, indicated Resident 4 required assistance with medication administration. Resident 4's record did not contain evidence of a written order for staff to administer medications to Resident 4. On 07/21/2025, at 2:10 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A confirmed Resident 4 required staff assistance with medications. Licensee A reported s/he did not obtain a written order for staff to administer medications to Resident 4.	M 464		
M 512	88.09(1)(e) RESIDENT'S RECORD RETENTION The licensee shall retain a resident's record for at least 7 years after the resident's discharge. The record shall be kept in a secure, dry place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 (Resident 4) resident records reviewed were retained for at least 7 years after the resident's discharge. Findings include:	M 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 512	Continued From page 12 On 07/21/2025, at 9:50 AM, Surveyors requested Resident 4's records for review. Resident 4 was admitted on 02/28/2025, with a diagnosis of quadriplegia. Resident 4 was admitted to the hospital on 06/30/2025 and did not return to the facility. Resident 4's record did not contain evidence of medication administration records (MARs). On 07/21/2025, at 2:10 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Surveyors inquired if Resident 4 had MARs during her/his stay. Licensee A confirmed Resident 4 had MARs but the MARs for Resident 4 were given to her/his family by a staff member when they picked up her/his belongings after discharge.	M 512		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not allow 1 of 1 resident (Resident 4)	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 556	Continued From page 13	M 556		

to return to the facility after a 30-day discharge notice took effect. On 07/07/2025, the provider did not allow Resident 4 to return to the facility.

Findings include:

On 07/03/2025, the Department received a complaint that alleged the provider would not allow a resident to return to the facility after a hospital admission.

On 07/21/2025, Surveyors reviewed the 30-day written discharge notice, dated 06/02/2025. The written notice read: "As of June 2nd, 2025, Living Insight Adult Family home has decided to issue [Resident 4] [sic] a 30-day discharge notice...we took [her/him] in on the strength that it was temporary as we already had a member looking to move in permanently within a month's [sic] time ...today will be day 95 ... [her/his] discharge date will be July 1st, 2025..."

On 07/21/2025, Surveyors reviewed emails from Licensee A to the Managed Care Organization (MCO), dated 06/02/2025. Licensee A emailed the MCO the 30-day discharge notice at 12:15 PM on 06/02/2025. The MCO acknowledged the 30-day notice via email on 06/02/2025 at 1:03 PM. The MCO email read "...30-day notice acknowledged".

Surveyors reviewed a note in Resident 4's file which indicated, "On July 7, 2025 [Resident 4's] friends ... came to get [her/his] wheel chair [sic] and all of [her/his] belongings. Staff present: [Caregiver C]. The time was 6:30 PM."

On 08/11/2025, Surveyors reviewed Resident 4's discharge paperwork from his/her hospital admission from 06/30/2025 to 07/17/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018537	A. BUILDING: _____ B. WING _____	R-C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING INSIGHT ADULT FAMILY HOME	3525 NORTH 20TH STREET MILWAUKEE, WI 53206

(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 556	Continued From page 14 Resident 4's discharge planning evaluation indicated the following: On 07/05/2025 at 7:22 AM, social worker (SW) called the facility. The voicemail message indicated residents went out with their family over the holiday weekend and there were no staff available until Monday. On 07/07/2025, "SW received a phone call from [Licensee A] ...SW informed from [Licensee A] that patient's group home will not be accepting patient back. [Licensee A] informs SW that the [group home] had a 30 [sic] day notice place 'anyway'; that expired on 07/02 ...[Licensee A] additionally reports that patient was only residing at the [Adult Family Home] on respite prior to patient's current hospital stay ..." Surveyors did not review any evidence of Resident 4 received a 30-day discharge notice. On 08/21/2025, at 12:15 PM, Surveyor interviewed Licensee A and House Manager B. Licensee A reported s/he did not call the hospital on 07/07/2025, but the hospital contacted her/him. Licensee A reported it was not policy to accept residents back from the hospital during the weekend because their pharmacy was not open during the weekends. Licensee A reported s/he would not accept Resident 4 back due to all her/his belongings were picked up on Sunday. Summary: Resident 4 was not allowed back to the facility on 07/07/2025 after her/his admission to the hospital.	M 556		