STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018572	A. BUILDING: _____ B. WING _____	C 07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL DWELLINGS AFH	4408 NORTH 39TH STREET MILWAUKEE, WI 53209

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M 000	INITIAL COMMENTS On 07/07/2025, Surveyors completed a standard survey and 2 complaint investigations at Peaceful Dwellings. As a result, 17 deficiencies were identified. Two complaints were substantiated. Census: 0	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 interview, the provider did not ensure the home, and its operation complied with this chapter, which had the potential to affect 3 of 3 residents residing in the home. During this standard survey, 17 deficiencies were identified. Findings include: The facility was licensed on 10/25/2021, to provide care to up to 4 ambulatory residents in the client groups of advanced age, developmentally disabled, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and terminally ill. Current census is 0. On 06/18/2025, Surveyors conducted a standard survey. Eighteen violations, including this violation, were identified during the time of the survey. The following deficiencies were identified: 88.04(2)(a) Responsibilities	M 216		

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

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M 216	Continued From page 1 88.04 (2)(f) Condition Which Represents Risk or Harm 88.04(2)(g)1 Health Screening for Staff 88.05(3)(a) Homelike Environment 88.05(3)(l) Bedrooms-Privacy 88.05(4)(c)1 Exiting From The First Floor 88.05(4)(d)2.a Fire Safety Evacuation Plan Review 88.05(4)(d)2.b Fire Evacuation Annual Evaluation 88.05(4)(d)2.c Semi-Annual Fire Drills 88.06(2)(a) Admission- Health Exam 88.06(3)(d) Individual Service Plan 88.06(3)(f) Review of ISP 88.07(3)(a) Prescription Medications 88.07(3)(d) Medication - Written Order 88.10(3)(b) Privacy 50.065(2)(bb) Determine Final Disposition Of Charge 50.065(2)(bm) Out Of State Background Checks On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A regarding the deficiencies identified during the survey and compliant investigation. Licensee A reported residents were recently removed from the home. Licensee A reported s/he was unaware why residents were removed from the home. Licensee A confirmed the home was the raided by the Federal Bureau of Investigation (FBI) in October of 2024. Licensee A reported s/he believed the FBI presence at the home could have resulted in residents being removed from the facility. Surveyors inquired if there was paperwork because of the FBI raid of the home. Licensee A reported s/he did not have any paperwork regarding the raid of the home.	M 216		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM	M 230		

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M 230	Continued From page 2 The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on record review and interview, the licensee permitted the existence or continuation of a condition in the home which placed the health, safety or welfare of 3 of 3 residents' (Resident 1, Resident 2, and Resident 3) at substantial risk of harm. The Federal Bureau of Investigation (FBI) conducted a raid in the home in search of guns and drugs while Resident 1, Resident 2, and Resident 3 resided in the home. Findings Include: On 6/17/2025, at 2:00 PM, Surveyors reviewed FBI Criminal Complaint, dated 10/01/2024. The criminal complaint indicated the Adult Family Home (AFH) was referred to as "Target Location 1". The criminal complaint indicated, " ...over the course of this investigations, case agents have observed multiple suspected drug transactions at this location, primarily conducted by [Person E] on behalf of [Person F], with selected suspected drug transactions occurring on August 14, 2024, and August 20, 2024. On July 3, 2024, case agents intercepted wire communications wherein [Person F] directs [Person E], a known drug customer and member of [drug organization], to this location. [Person E] specially mentions having a 'ton of bags,' and described how s/he was trying to obtain 'woo' (cocaine). The residence's listed owner is [Licensee A], believed to be [Person F's] [sibling], and s/he is nominally	M 230		

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M 230	Continued From page 3	M 230		

using the residence as a group home. Law enforcement believes contraband and/or documentary evidence of [Person F's] drug trafficking will be located here, given [Person Fs] [sic] frequent use of this location and [her/his] prolific drug trafficking."

On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A first reported s/he was unaware the home was raided by the FBI. Licensee A later confirmed the AFH was raided by the FBI on 10/02/2024 but was unaware why the home was raided. Licensee A then reported s/he thought it had to do with an old warrant for Person E. Licensee A confirmed Resident 1, Resident 2, and Resident 3 were in the AFH during the time of the raid. Licensee A reported s/he first became aware of the suspected drug activity in the AFH from Provider Quality Manager (PQM) G. Licensee A stated, "As far as my knowledge, there was no drug activity in this home." Surveyors inquired if Person E and Person F were employed by Licensee A to work at the home. Licensee A first reported Person E and Person F were not employees, but later reported Person E and Person F completed maintenance work and "only worked outside" of the home. Licensee A reported s/he did not have staff files for Person E and Person F.

On 06/24/2025, at 8:38 AM, Surveyors interviewed PQM G. PQM G reported Licensee A initially responded with s/he was unaware of what PQM G was inquiring about. PQM G reported Licensee A, a few hours later, reported s/he did have a raid at the AFH but had forgotten about it. PQM G reported Licensee A then emailed PQM G and reported the concern was due to a previous employee retaliation and calling in a false complaint. PQM G reported Licensee A reported

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M 230	Continued From page 4 to PQM G s/he was breaking the law and defaming her/his character.	M 230		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation indicating 2 of 3 staff (Caregiver B and Caregiver D) been screened for communicable diseases, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service. Caregiver B and Caregiver D were not screened for TB prior to providing cares. Caregiver B and Caregiver D were not screened for communicable diseases before providing cares. Findings include: On 06/18/2025, at 12:27 PM, Surveyors reviewed employee records and identified the following:	M 232		

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M 232	Continued From page 5 Caregiver B was hired on 09/13/2023. Caregiver B's record contained a TB screening dated 03/24/2023, 173 days prior to start of providing service. Caregiver B's record contained a communicable disease screening questionnaire, dated 09/13/2023. The questionnaire did not contain a signature from a registered nurse, physician, or a physician assistant on her/his communicable disease screening. Caregiver B's record did not contain evidence Caregiver B was screened for communicable diseases. Caregiver B was not screened for TB within 90 days before the start of providing service. Caregiver D was hired on 05/08/2024. Caregiver D was not screened for TB within 90 days before the start of providing service. Caregiver D's record contained a communicable disease screening questionnaire, dated 09/27/2023. The questionnaire did not contain a signature from a registered nurse, physician, or a physician assistant on her/his communicable disease screening. Caregiver D's record did not contain evidence Caregiver D was screened for communicable diseases. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement but was unaware of the within 90 days before the start of providing service for Caregiver B's TB test. License A reported s/he was unaware registered nurse, physician, or a physician assistant was required to screen and sign the communicable disease screening.	M 232		
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 6 provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe, clean, and well-maintained homelike environment with the potential to affect 4 of 4 residents. The bathroom contained a mold-like substance and needed cleaning and repairs. One of the bedroom doors was missing. The kitchen contained a camera, and the exhaust fan had a thick grayish material stuck to it, similar to dust. Findings include: On 06/18/2025, at 9:55 AM, Surveyors toured the facility and observed the following: 1st Floor Bathroom - The windowsill, blinds, and area for a recessed soap holder in the tub area contained a black mold like substance. Surveyor used her/his fingernail and scratched at the black substance on the windowsill. The substance flaked off in chunks. - Tub finish was flaking and cracked around tub drain. This area measured approximately 4 inches by 7 inches. - All lightbulbs in the first-floor bathroom were missing.	M 276		

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M 276	Continued From page 7 Resident 1's bedroom - Bedroom door was missing. Kitchen - The kitchen exhaust fan contained thick greyish material similar to dust. - A camera was located next to the exhaust fan. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported the substance on the bathroom windowsill was not mold but the substance returns after being cleaned. Licensee A reported the bathroom lightbulbs were removed as a preventive measure for Resident 1. Licensee A reported Resident 1 had a history of breaking light bulbs and had previously broken her/his door.	M 276		
M 320	88.05(3)(l) BEDROOMS-PRIVACY A resident's bedroom shall provide comfort and privacy, shall be enclosed by full height walls and shall have a rigid door that the resident can open and close. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility did not ensure privacy for 1 of 4 resident bedrooms. Resident 1's bedroom, located on the first floor, did not contain a door. Findings include: On 06/18/2025, at 9:55 AM, Surveyors toured the	M 320		

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M 320	Continued From page 8	M 320		

facility. The facility was a 4-bedroom house. The facility was able to serve up to 4 residents. Surveyors did not observe a door for Resident 1's bedroom.

On 06/18/2025, at 12:27 PM, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 03/28/2023 with diagnoses including mild intellectual disability, major depressive disorder, schizoaffective disorder, and post-traumatic stress disorder. Resident 1's record did not contain an individual service plan (ISP).

Surveyors reviewed an incident report, dated 02/24/2025, which indicated at 8:00 AM, Resident 1 was being escorted to her/his room. Resident 1 slammed room door and held door closed for approximately 20 minutes. Staff climbed through facility window to redirect Resident 1 away from the door. Resident 1 stuck a foreign object from her/his door in a wound on her/his arm.

On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Surveyors inquired if Licensee A was aware of the requirement for a resident's bedroom to have a rigid door for privacy. Licensee A reported s/he was aware of the requirement. Licensee A reported Resident 1 broke the door during a "high behavior state" on 02/24/2025. Licensee A reported s/he removed the damaged door on 02/24/2025. Licensee A reported the damaged door was not replaced due to not finding a suitable alternative replacement due to Resident 1's history of destructive behaviors. Licensee A reported s/he wanted a barn-style door. Licensee A reported Resident 1 moved out of the facility on 06/06/2025.

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M 338	Continued From page 9	M 338		
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 1 of 2 exits. There were several objects blocking the rear exit. The security door contained a double cylinder deadbolt that was engaged and required a key to exit the facility. Findings include: On 06/18/2025, at 9:55 AM, Surveyors toured the facility. Surveyors observed a rear exit located in the kitchen. The doorway was obstructed by cleaning supplies, a step ladder, and a garbage can. Surveyors were able to open the door 23 inches. Through the rear exit kitchen door, there was one step down to a landing leading to the outside rear exit door. On the landing were 4 blue commercial water jugs obstructing the exit door. Surveyors were able to open the door 8 inches. Once the main door was opened, Surveyors observed a security door. The security door contained a double cylinder deadbolt. The deadbolt was engaged and required the use of a key to exit the facility. On 06/18/2025, at 10:26 AM Surveyors reviewed a floor plan of the facility. The floor plan identified	M 338		

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M 338	Continued From page 10 the rear exit as an emergency exit. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported the water jugs were not always placed by the rear exit door. Licensee A reported s/he would ensure the water jugs would be removed. Licensee A reported both exits contained a double cylinder deadbolt on the security doors due to elopements. Licensee A reported staff would have the key to unlock the double cylinder deadbolts. Licensee A confirmed residents did not carry the key. Licensee A reported the managed care organization (MCO) told them to put them on as an intervention.	M 338		
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 complete the resident evacuation assessment within 3 days of admission for 3 of 3 residents. Resident 1, Resident 2, and Resident 3 did not have resident evacuation assessments completed. Findings include:	M 344		

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M 344	Continued From page 11 On 06/18/2025, at 12:27 PM, Surveyors reviewed resident records and identified the following: - Resident 1 was admitted to the facility on 03/28/2023 with diagnoses including mild intellectual disability, major depressive disorder, schizoaffective disorder, and post-traumatic stress disorder. Resident 1's record contained an evacuation assessment dated 03/28/2023. The evacuation assessment was blank. Resident 1's record did not contain any evidence of a completed evacuation assessment. -Resident 2 was admitted on 06/21/2023 with a diagnosis of autistic disorder. Resident 2's record contained an evacuation assessment dated 06/21/2023 The evacuation assessment was blank. Resident 2's record did not contain any evidence of a completed evacuation assessment. - Resident 3 was admitted to the facility on 09/20/2022 with diagnoses including traumatic brain injury (TBI) and psychiatric disorder. Resident 3's record contained an evacuation assessment dated 09/21/2022. The evacuation assessment was blank. Resident 3's record did not contain any evidence of a completed evacuation assessment. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed the requirement to have the evacuation assessments completed immediately after admission. Licensee A reported s/he went over evacuation assessment with residents during admission agreement but was not able to go back and update forms.	M 344		

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M 346	Continued From page 12	M 346		
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 complete an annual evacuation assessment review for 3 of 3 residents who lived in the facility beyond one year. Resident 1 and Resident 2 did not have an evacuation assessment completed in 2024. Resident 3 did not have an evacuation assessment completed in 2023 or 2024 Findings include: On 06/18/2025, at 12:27 PM, Surveyors reviewed resident records and identified the following: - Resident 1 was admitted to the facility on 03/28/2023 with diagnoses including mild intellectual disability, major depressive disorder, schizoaffective disorder, and post-traumatic stress disorder. Resident 1's record did not contain evidence of a completed or updated evacuation evaluation in 2024. - Resident 2 was admitted to the facility on 06/21/2023 with a diagnose of autistic disorder. Resident 2's record did not contain evidence of a completed or updated evacuation evaluation in 2024.	M 346		

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M 346	Continued From page 13 - Resident 3 was admitted to the facility on 09/20/2022 with diagnoses including traumatic brain injury (TBI) and psychiatric disorder. Resident 3's record did not contain evidence of a completed or updated evacuation evaluation in 2023 or 2024. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported s/he was unaware of the code requirement. Licensee A confirmed there were no annual evacuation assessments in resident records.	M 346		
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 ensure semi-annual fire drills were conducted and documented with the date and the evacuation time for each drill for 2 of 2 years. There was no documentation of fire drills being conducted in 2023 and 2024. Findings include: On 06/18/2025, at 10:26 AM Surveyors reviewed the facility safety files. There was no evidence of fire drills being conducted in 2023 and 2024. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported s/he and staff were responsible to complete fire drills.	M 348		

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M 348	Continued From page 14 Licensee A reported s/he believed the drills were completed but did not have documentation.	M 348		
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 each resident admitted to the facility was screened for communicable disease, including tuberculosis (TB), within 90 days prior to placement or within 7 days after admission for 3 of 3 residents. Resident 1, Resident 2, and Resident 3 did not have evidence of a completed communicable disease screening. Findings include: On 06/18/2025, at 12:27 PM, Surveyors reviewed resident records and identified the following: - Resident 1 was admitted to the facility on 03/28/2023. Resident 1 had a TB test completed on 07/16/2024, 476 days after admission.	M 380		

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M 380	Continued From page 15 Surveyors did not review any evidence of a completed screening for communicable disease, including TB, within 90 days prior to placement or within 7 days after admission in Resident 1's record. - Resident 2 was admitted to the facility on 06/21/2023. Resident 2 had a TB test completed on 07/16/2024, 391 days after admission. Resident 2's record contained a blank communication disease screening. Surveyors did not review evidence for screening of communicable disease, including TB, within 90 days prior to placement or within 7 days after admission in Resident 2's record. - Resident 3 was admitted to the facility on 09/20/2022. Resident 3's record contained a blank communication disease screening. Resident 3 had a TB test completed on 10/07/2022, 17 days after admission. Surveyors did not review evidence for screening of communicable disease, including TB, within 90 days prior to placement or within 7 days after admission in Resident 3's record. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported s/he was unaware of the code requirement. Licensee A did not offer any further information.	M 380		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following:	M 410		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 3 of 3 residents' (Resident 1, Resident 2, and Resident 3) Individual Service Plan (ISP) included all required information. Resident 1 did not have an ISP. Resident 2's and Resident 3's ISPs did not include all of the following:

1. A description of the services the licensee will provide to meet assessed needs.
2. Identification of the level of supervision required in the home and community.
3. Identification of who will monitor the plan.
4. Signed statement of agreement.

Findings include:

On 06/18/2025, at 12:27 PM, Surveyors reviewed resident records and identified the following:

Resident 1
- Resident 1 was admitted to the facility on 03/28/2023 with diagnoses including mild intellectual disability, major depressive disorder, schizoaffective disorder, and post-traumatic stress disorder. Resident 1's record contained a blank form labeled "Adult Family Home Individualized Service plan". Surveyors did not review any evidence of a written assessment or an ISP for Resident 1.

Resident 1's behavior support plan (BSP), dated 08/06/2024, indicated Resident 1 exhibited self-injurious behaviors, aggressiveness towards staff, sexual behaviors, and elopement.

Behavioral Triggers

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M 410	Continued From page 17 - Physical well-being which includes tiredness, fatigue, thirst, illness/pain - Communication - at times will not express her/his feelings verbally - Change in routine - Lack of control or choice - Transitions between activities - Being told "no" - Environmental irritations which included disruption, crowds, dust, cigarette smoke, loud noises (yelling, music), new staff members. - Pre-existing abuse issues Interventions - Physical well-being - "staff must assess [Resident 1's] needs for drink, sleep, and medical attention before any further intervention." - Communication - "Staff is to approach [her/him] and ask if they can be invited into [her/his] safe space. Based on [Resident 1's] non-verbal response staff will offer a gentle hug/embrace, hand holding, a listening ear, kind and encouraging words, snack/drink or any medication intervention" - Change in routine - "[Resident 1] does [her/his] best when [s/he] knows what to expect. Keeping a consistent schedule is helpful." - Lack of control or choice - " Be creative in how	M 410		

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expectations are offered to [Resident 1]. Use humor, offer choices, give time, etc."

- Transitions between activities - Foreshadow an upcoming transition. Give the person something to do during transition. Provide a positive focus for the current activity.

- Being told "no" - Try to avoid the word "no". Use redirection techniques. That is, instead of saying what the person cannot do, describe what they can do as an alternative.

- Environmental irritations - "Pay attention to the environment. Seemingly minor factors such as individuals engaging and not including [her/him] can adversely impact [Resident 1]. Also, create, or guide [Resident 1] to environments relatively free from 'irritants."

Surveyors reviewed Milwaukee County Behavioral Health Services Crisis Plan dated 10/31/2023. The crisis plan identified Resident 1 as very attention - seeking and very needy. The crisis plan included behaviors of self-harm, threats of harm to others, somatic complaints to go to the hospital, and impulsiveness.

The crisis plan identified coping skills and de-escalation strategies to include Resident 1 will call her/his supports, talk with residential staff, call the crisis line, doing artwork, reading, journaling, listening to music, deep breathing, sleeping, and going for a walk.

Surveyors reviewed Police Safety Plan dated 10/31/2023 which indicated Resident 1 received 1 to 1 staff supervision. The safety plan identified self-injurious behaviors which included ingesting items, inserting items under skin, running int

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traffic and lay in street, making suicidal statements, elopement, and aggressiveness to others.

Surveyors reviewed incident reports and identified the following:

- 06/01/2025, at 9:55 PM, staff returned to common area after doing rounds on another resident, Resident 1 was found in the basement with a knife. Resident 1 had cuts on her/his arm, stabbed herself/himself in the stomach, and slit her/his nose. Resident 1 was sent to the emergency room (ER).

- 02/24/2025, at 8:00 AM, Resident 1 was being escorted to her/his room. Resident 1 slammed room door and held door closed for approximately 20 minutes. Staff climbed through facility window to redirect Resident 1 away from the door. Resident 1 stuck a foreign object from her/his door in a wound on her/his arm.

- 05/29/2023, at 2:00 PM, Resident 1 inserted a screw in her/his arm. Resident 1 attacked staff. Resident 1 bit, kicked, and punched staff because she/he wanted to leave the facility and go to the hospital. Resident 1 caused property damage while police were present. Resident 1 was sent to ER.

- 05/28/2023, at 10:00 AM, Resident 1 swallowed a toe ring and inserted a toe ring in an open wound.

- 04/10/2023, at 11:30 AM, Resident 1 removed a nail from the bathroom drawer and punctured her/his left arm again. Resident 1 attempted to escape residence. Resident caused property damage and placed a battery in her/his mouth.

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M 410	Continued From page 20 Resident 1 attempted to put pillowcase over her/his head to suffocate herself/himself. - 04/07/2023, at 11:15 AM, Resident 1 inserted a nail into an open wound on her/his left shoulder. Resident 1 was sent to ER. Resident 2 Resident 2 was admitted to the facility on 06/21/2023 with a diagnosis of autistic disorder. Resident 2's file indicated s/he had a guardian. Resident 2's record contained a form labeled "Adult Family Home Individualized Service plan" which was undated. Resident 2's ISP did not include specific description of services, specific information about the type of supervision required in the home and the community or include who was responsible for monitoring the plan. Resident 2's ISP was signed by Licensee A but was not signed by her/his guardian and her/his managed care organization (MCO). Activities of Daily Living - Bathing - teaching, reminders, supervision, full care - Hair care - reminders, supervision, full care - Teeth - independent - Shaving - supervision, full care - Dressing - independent, reminders Behavioral Intervention - "yes member needs constant redirection when it comes to [sic]." The ISP did not describe what behaviors needed redirection. Resident 2's ISP did not mention they had a BSP for staff to implement. Medication Management	M 410		

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M 410	Continued From page 21 - Yes Communication - "member is nonverbal:" Resident 2's ISP did not describe how staff were to communicate with her/him. Supervision - "Yes... Member can spend 0 hours at a time unsupervised.. member is a I:I retreat [sic]." Resident 2's BSP, dated 07/30/2024, indicated Resident 2 had behaviors which included physical aggression, sexual aggression/ inappropriate behaviors, feces smearing, property destruction, throwing objects, and breaking things. Behavioral Triggers - Physical well-being which includes tiredness, fatigue, thirst/hunger, illness/pain, hygiene, and meals - Communication which included non-verbal; not being able to express needs and wants. - Change in routine - Lack of control or choice - Transitions between activities - Being told "no"/"stop" - Environmental irritations which included disruption, crowds, frustration, showers, loud noises (yelling, music, crying), new staff	M 410		

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members, redirection (being told what to do) or not knowing what to do, words like no/stop

Interventions

- Physical well-being - "staff must assess [Resident 2's] needs for drink, sleep, and medical attention before any further intervention."

- Communication - "Staff is to approach [her/him] and ask if they can be invited into [her/his] safe space. Based on [Resident 2's] non-verbal response staff will offer a gentle hug/embrace, hand holding, a listening ear, kind and encouraging words, snack/drink or any medication intervention"

- Change in routine - "[Resident 2] does best when [s/he] knows what to expect. Keeping a consistent schedule is helpful, and rendering many cues"

- Lack of control or choice - " Be creative in how expectations are offered to [Resident 2]. Use humor, offer choices, give time, be patient, and be gentle, etc."

- Transitions between activities - Foreshadow an upcoming transition. Give the person something to do during transition. Provide a positive focus for the current activity.

- Being told "no"/"stop" - Try to avoid the word "no" or "stop". Use redirection techniques. That is, instead of saying what the person cannot do, describe what they can do as an alternative.

- Environmental irritations - "Pay attention to the environment. Seemingly minor factors such as individuals engaging with [her/him] too much, too

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M 410	Continued From page 23 long, or interrupting [her/his] movies or shows will impact [Resident 2] a lot. Also, create, or guide [Resident 2] to environments relatively free from 'irritants." Resident 3 - Resident 3 was admitted to the facility on 09/20/2022 with diagnoses including traumatic brain injury (TBI) and psychiatric disorder. Resident 3's file indicated s/he had a guardian. Resident 3's record contained an ISP dated 09/20/2022. Resident 3's ISP was signed by Licensee A but was not signed by her/his guardian or her/his MCO. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported s/he was responsible for completing resident ISP's. Licensee A reported s/he believed Resident 1's ISP was taken with her/him when s/he was removed from the facility. Licensee A did not offer further information for Resident 2's and Resident 3's ISP's missing signatures from all parties involved. Surveyors relayed concerns about all resident needs, behaviors and interventions needed to be identified in the resident's ISP. Licensee A acknowledged Surveyors concerns.	M 410		
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	M 424		

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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 ensure 2 of 3 residents' (Resident 2 and Resident 3) individual service plans (ISPs) were reviewed at least once every 6 months. Resident 2's ISP was due to be reviewed in 12/2023, 06/2024, and 12/2024. Resident 3's ISP was due to be reviewed in 03/2023, 09/2023, 03/2024, 09/2024, and 03/2025.

Findings include:

On 06/18/2025, at 12:27 PM, Surveyors reviewed resident records and identified the following:

- Resident 2 was admitted to the facility on 06/21/2023, with a diagnosis of autistic disorder. Resident 2's. Resident 2's record contained an initial ISP, which was not dated. Resident 2's ISP was due to be reviewed in 12/2023, 06/2024, and 12/2024.

- Resident 3 was admitted to the facility on 09/20/2022, with diagnoses including traumatic brain injury (TBI) and psychiatric disorder. Resident 3's record contained an initial ISP dated 09/20/2022. Resident 3's ISP was due to be reviewed in 03/2023, 09/2023, 03/2024, 09/2024,

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M 424	Continued From page 25 and 03/2025. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported s/he updated ISPs once a year or with a change in condition. Licensee A reported s/he was unaware of where the information was. Licensee A reported s/he would send the information to Surveyors. As of 06/24/2025, at 11:30 AM, Surveyors have not received the requested information.	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 and interview, the provider did not ensure over the counter (OTC) medications were securely stored for 1 of 1 storage area. Medications were stored in an unlocked closet on the second floor in the common closet on a rolling cart. Unsecured medications had the potential to affect 4 of 4 residents.	M 458		

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M 458	Continued From page 26 Findings include: On 06/18/2025, at 9:55 AM, Surveyors toured the facility. Surveyors observed the upstairs closet located at the top of the stairs. Surveyors did not observe a locking mechanism on the hallway closet. Surveyors observed a rolling cart containing OTC medications which included: 2 boxes of Theraflu severe cold relief, Vicks vapor steam, Vicks VapoCool sore throat, and Walgreens cold and flu. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed OTC medications should be securely stored and locked. Licensee A reported the medications on the rolling cart in the upstairs closet were used as an isolation cart and placed outside of a resident's room as needed. Licensee A confirmed this cart was used for residents.	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.	M 464		

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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 resident, stating who can administer the medications for 3 of 3 residents. Resident 1's, Resident 2's, and Resident 3's records did not contain a written order to administer medications.

Findings include:

On 06/18/2025, at 12:27 PM, Surveyors reviewed resident records and identified the following:

- Resident 1 was admitted to the facility on 03/28/2023, with diagnoses including mild intellectual disability, major depressive disorder, schizoaffective disorder, and post-traumatic stress disorder. Resident 1's record contained a behavior support plan (BSP) dated 08/06/2024. The BSP stated Resident 1's medication were to be locked in a cabinet and administered by staff for her/his safety. Resident 1's record did not contain evidence of a written order from a physician for staff to administer medications.

- Resident 2 was admitted to the facility on 06/21/2023, with a diagnosis of autistic disorder. Resident 2's. Resident 2's record contained a medication administration record (MAR) dated 04/24/2025 - 05/23/2025, which identified staff administered medications to Resident 2. Resident 2's record did not contain evidence of a written order from a physician for staff to administer medications.

- Resident 3 was admitted to the facility on 09/20/2022, with diagnoses including traumatic brain injury (TBI) and psychiatric disorder. Resident 3's record contained a MAR dated

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PEACEFUL DWELLINGS AFH	4408 NORTH 39TH STREET MILWAUKEE, WI 53209

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M 464	Continued From page 28 04/24/2025 - 05/23/2025, which identified staff administered medications to Resident 3. Resident 3's record did not contain evidence of a written order from a physician for staff to administer medications. On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed Resident 1, Resident 2, and Resident 3 needed staff assistance for medication administration. Licensee A reported s/he needed to create a document which stated who can administer physician prescribed medications at the facility.	M 464		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident had privacy in living arrangements with potential for affecting 4 of 4 residents. There were electronic video and audio monitoring cameras mounted in the living room,	M 550		

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M 550	Continued From page 29	M 550		

kitchen, second floor hallway, and outside above a common area used by residents.

Findings include:

On 06/18/2025, at 9:55 AM, Surveyors toured the facility and observed the following:

Living Room

- The camera located on the west wall. The camera was pointed towards the couches.

Kitchen

- The camera located on the south wall. The camera was pointed towards the entryway into the kitchen.

Second Floor Hallway

-The camera was located on the south wall. The camera was pointed down the hallway towards a bedroom and bathroom.

Outside Camera

- The camera located on the south facing exterior wall. The camera was pointed towards the common area.

Surveyors observed a monitor located on the east wall of the kitchen next to the refrigerator. Surveyors hit the camera icon on the bottom of the monitor screen and observed the following:

"Indoor Cam"
- In the camera view, Surveyors observed the living room, which included the couch, love seats, entrance to the kitchen, stairway to second floor,

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M 550	Continued From page 30 medication closet, and entrance to bathroom. "Side" - In the camera view, Surveyors observed three red folding chairs, a wooden porch swing, and a table. There was a sign which indicated "designated smoking area". On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A confirmed the living room, kitchen, second floor hallway, and outdoor seating area were used by residents. Licensee A reported the cameras had no current subscription and did not work. When Surveyors inquired why the cameras were still in place if they were not active, Licensee A reported the cameras were installed due to theft of facility supplies and for safety of Resident 1 due to a history of self-harm. Surveyors inquired why the monitor was active and recording if the cameras did not work. Licensee A reported s/he used the cameras for safety. Surveyors relayed concerns regarding resident privacy.	M 550		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under	Z 010		

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Z 010	Continued From page 31 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure every reasonable effort was made to contact the clerk of courts to determine the final disposition of a charge of a serious crime, related to s. 948.21(2), for 1 of 1 caregiver (Caregiver D). Findings include: On 06/18/2025, at 12:27 PM, Surveyors reviewed Caregiver D's file. The documents reviewed included background information disclosure form (BID), a State of Wisconsin Department of Justice (DOJ) background check, and caregiver background check (IBIS).	Z 010		

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Z 010	Continued From page 32 Caregiver D was hired as a caregiver on 05/08/2024. BID - The BID was completed and signed on 09/11/2023, by Caregiver D. - Caregiver D did not disclose s/he was convicted of a crime. DOJ - The DOJ record was requested and reported on 09/27/2023. - "Date of offense: 09/29/2021. . . 948.21(2) - Child Neglect...Disposition date: 07/14/2022. Disposition: Convicted" IBIS - The IBIS record was requested and reported on 09/27/2023. - No findings - No denials - No exclusions - No rehabilitation review findings - No professional credential, license or certificate found On 06/18/2025, at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported Caregiver D was a rehire but did not confirm original date of hire. Licensee A reported s/he was aware of Caregiver D's charge but did not believe it restricted her/him from working at the facility. Licensee A reported s/he was aware background checks were to be completed but was unsure of how to read them.	Z 010		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS	Z 012		

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Z 012	Continued From page 33 If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on interview and record review, the program did not ensure 1 of 3 staff (Caregiver B) out of state background checks, for staff living out of state within the last three years, were completed. Findings Include:	Z 012		

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Z 012	Continued From page 34 On 06/18/2025, at 12:27 PM, Surveyors reviewed employee records and identified the following: - Caregiver B was hired on 09/13/2023. Caregiver B's background information disclosure form (BID) indicated Caregiver B lived in Arizona within the last 3 years (4/2021 to 9/2023). No evidence of an out of state background check was identified in her/his file. On 06/18/2025 at 1:45 PM, Surveyors interviewed Licensee A. Licensee A reported s/he was unaware of the code requirement. Licensee A reported s/he was unsure about background checks.	Z 012		