STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020376	A. BUILDING: _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEOPLES PLACE (THE)	**2330 E CHESTNUT DR OAK CREEK, WI 53154**

(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 06/25/2025, with information gathered through 07/31/2025, Surveyor completed 2 complaint investigations at The Peoples Place. As a result, 4 deficiencies were identified. Two of 2 complaints were substantiated. Census: 3	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action	M 114		

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

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M 114	Continued From page 1 provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee (Caregiver B) reviewed had a complete background check conducted at the time of hire. A complete background check consists of the following: 1. A completed Background Information Disclosure (BID) form 2. A response from the Department of Justice (DOJ) 3. A Governmental Findings Report (IBIS) from the Department of Health Services (DHS) Findings include: On 07/07/2025, at approximately 1:35 PM, Surveyor reviewed Caregiver B's file and identified the following: - Date of hire - 04/09/2025 - Completed a BID on 04/09/2025 - A DOJ and IBIS were requested on 07/02/2025, 84 days after Caregiver B's hire date (7 days after the start of this survey) Caregiver B's record did not contain evidence of a background check being completed within 60	M 114		

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M 114	Continued From page 2 days of employment. On 07/31/2025, at 9:00 AM, Surveyor interviewed Licensee A and the following was reported: Service providers were asked to complete a BID upon hire. After orientation and training were completed, then Licensee A requested DOJ and IBIS reports. Licensee A was not aware of the requirements for caregiver background checks.	M 114		
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 physical privacy in living arrangements for 3 of 3 residents (Resident 1, Resident 2, and Resident 3) residing in the home. There was an electronic video monitoring camera on the television (TV) stand in the living room of the adult family home (AFH).	M 550		

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M 550	Continued From page 3 Findings include: On 07/02/2025, at 11:02 AM, Surveyor observed a camera on top of the TV stand in the living room of the AFH. The camera was actively moving along with Surveyor's movement within the living room. Residents were observed freely walking in the living room. On 07/02/2025, at 12:26 PM, Surveyor interviewed Licensee A and the following was reported: The camera was placed in the living room a few weeks ago. S/He had the camera there to monitor the medication closet. S/He received a random call from someone stating they were the Drug Enforcement Administration (DEA) and they discussed theft of medications. After calling the police to see if the random phone call was legitimate, s/he decided to place the camera in the home. S/He confirmed the camera recorded movement and audio. S/He was unaware the placement of the camera was a violation of the residents' privacy. On 07/31/2025, at 9:00 AM, Surveyor interviewed Licensee A and s/he reported the camera would be removed.	M 550		
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.	M 556		

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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 interview and record review, the provider did not ensure the resident right to self-direction was respected or promoted for 1 of 1 resident (Resident 1) in the home. Resident 1 was removed from adult day program against her/his wishes.

Findings include:

On 06/25/2025, with information gathered through 07/31/2025, Surveyor conducted a complaint investigation at the facility.

On 06/25/2025, at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A reported Resident 1 attended adult day program at a center on Mondays, Wednesdays, and Fridays (MWF). S/He reported Resident 1 had not been attending day program recently due to what another resident in the adult family home (AFH) said to her/him. Licensee A reported another resident in the home (s/he did not specify which resident) told Resident 1 adult day program was for "babies." S/He reported since then, Resident 1 had not wanted to go back to day program.

On 06/26/2025, at 2:31 PM, Surveyor interviewed Adult Day Center Coordinator (ADCC) C and the following was reported:

Resident 1 began attending adult day program on 04/28/2025 and attended 3 times weekly on

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MWF. There were arrangements for Resident 1 to be transported to/from her/his AFH to adult day program by a transportation company. ADCC C knew Resident 1 to have been a "calm/chill [wo/man]." On 06/09/2025, Resident 1 was attending adult day program and told ADCC C s/he was going to start breaking windows so the police could come take her/him so s/he did not have to return to her/his AFH. Resident 1 told ADCC C Licensee A was hurting her/him and not helping her/him. The police were contacted to report Resident 1's allegations. Prior to police arrival, Licensee A showed up at Resident 1's adult day program center to pick her/him up. ADCC C stated this was unusual because Licensee A had never picked up Resident 1 at the center, s/he had always been transported by the transportation company. Since being picked up by Licensee A on 06/09/2025, Resident 1 had not returned to adult day program. Surveyor inquired about Resident 1's demeanor and overall participation while at adult day program. ADCC C reported Resident 1 had always participated and socialized while at the center. Resident 1 enjoyed the arts and crafts, ate every meal, and was overall "pretty active." ADCC C had an understanding Aurora provided the funding to Licensee A for Resident 1 to attend adult day program.

On 07/02/2025, at 10:10 AM, Surveyor interviewed Resident 1 at the AFH. Surveyor inquired if Resident 1 had been attending an adult day program. Resident 1 stated, "I want to get out of here. I want to go to day program." Surveyor inquired if Resident 1 enjoyed the adult day program and if s/he would have liked to continue attending. Resident 1 stated, "It's better than here. I don't want to stick with this [wo/man]; [S/He's] going to kill me."

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M 556	Continued From page 6 On 07/02/2025, Surveyor reviewed facility documents and Resident 1's files, to include Resident 1's daily progress notes and daily evaluation chart beginning with 05/23/2025 through 06/27/2025. It was noted on the following dates Resident 1 had attended day program: 05/23/2025, 05/28/2025, 05/30/2025, 06/02/2025, 06/04/2025, 06/06/2025, 06/09/2025. These dates were consistent with Resident 1's MWF day program schedule, with the exception of 05/26/2025, which was a holiday the center was closed and did not hold day program services. After 06/09/2025, Resident 1's files did not note attendance at day program, and did not note any incidents or refusals leading to Resident 1's absence from the center. No documentation was made on day program attendance for the following scheduled dates: 06/11/2025, 06/13/2025, 06/16/2025, 06/18/2025, 06/20/2025, 06/23/2025, 06/25/2025, 06/27/2025. A daily progress note from 3rd shift on 06/13/2025, written by Caregiver D, documented, "[Resident 1] was talking about harming supervisor saying [s/he] could make a shank and kill somebody and supervisor [s/he] said [s/he] has crazy thoughts [s/he] doesn't want to hurt anyone [s/he] said hospital give [her/him] money for [her/him] and [s/he] doesn't let [her/him] go anywhere . . . " On 07/31/2025, at 6:43 AM, Surveyor interviewed ADCC C, and s/he confirmed the last date of attendance for Resident 1 at the adult day program was on 06/09/2025. ADCC C reported s/he has not received payment on Resident 1's account, or any communication for Resident 1's dis-enrollment from the center. On 07/31/2025, at 9:00 AM, Surveyor interviewed Licensee A and the following was reported:	M 556		

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M 556	Continued From page 7 Resident 1 had been attending adult day program on MWF. S/He was transported to/from the center by City Wide Transportation, which had been setup by Licensee A. Resident 1 last attended adult day program in June; Licensee A did not recall the exact date. Licensee A stated, "[Resident 1] has decided that [s/he] does not want to go to day program after everything transpired. So unfortunately, [s/he] has not been . . . It was my call anyway. The hospital was not paying me for that. That was coming out of my personal pocket to pay for [her/him] to go to day program." Surveyor inquired about Licensee A's conversation with Police Officer (PO) E on 06/09/2025. S/He did not recall ever speaking with the police about anything regarding Resident 1. Surveyor informed Licensee A the police report documented PO E told Licensee A about Resident 1's request to find new placement. PO E reported Licensee A was going to work with Aurora Healthcare to help find Resident 1 new placement. Surveyor inquired what Licensee A has done to help Resident 1 find new placement. Licensee A reported s/he did not speak with police and was not made aware Resident 1 wanted new placement. Surveyor inquired what Resident 1's typical day looked like, and s/he reported Resident 1 liked watching TV, walking, coloring, and painting. Surveyor inquired what would happen if Resident 1 expressed s/he would like to attend day program. Licensee A stated, "If [s/he] ever says that [s/he] wants to go to day program, that's something I will think about. As far as if it's in my budget for me to afford that at this moment."	M 556		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT	M 610		

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M 610	Continued From page 8 A licensee or service provider who knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the licensing agency was immediately notified when there were allegations of caregiver misconduct affecting 1 of 3 residents in the home. Licensee A did not report an allegation of abuse Resident 1 stated to a caregiver, who reported to Licensee A. Findings include: On 06/11/2025 and 07/24/2025, the department received complaints alleging Licensee A hit a resident on the arms and legs, tripped her/him, and slammed a door on her/his arm, causing bruising and swelling on her/his legs and arms. On 06/23/2025, Surveyor reviewed Department	M 610		

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records for The Peoples Place and did not observe documentation Licensee A or a service provider notified the Department of allegations of abuse or neglect.

Record Review - Resident 1's File

On 06/25/2025, at 10:03 AM, Surveyor reviewed Resident 1's file and identified the following:

- Resident 1 was admitted on 02/20/2025, with diagnoses including vascular dementia with intermittent behavior disturbance, history of cerebrovascular accident (stroke) with residual right side choreatic movement of hand and eye, hip osteoarthritis, hepatic steatosis with suggestion of early cirrhosis, and peptic ulcer disease.
- Resident 1 was [her/his] own person and was funded by Aurora Healthcare.

Surveyor located 2 accident/incident reports in Resident 1's file. The first report was dated 03/23/2025, at 3:30 PM, and was written and signed by Licensee A on 03/23/2025, at 3:45 PM. The report stated, "[Resident 1] attempted to walk out of the facility. Staff assisted [Resident 1] outside where [s/he] was attempting to leave. Staff tried to redirect [Resident 1] to just get some air. [Resident 1] attempted to become physically combative with staff. [Resident 1] end up fall backward into the house where [s/he] began to kick [sic]. Staff let [Resident 1] calm down before attempting to help [her/him] up. [Resident 1] has a small bruise on the top of [her/his] head. A bruise on the top of [her/his] foot and left hand. Staff iced all bruises. No severe injuries that would require medical attention." An anatomical diagram accompanied the report and pen marks were made on top of the right hand, top of the

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right foot, and on the right side of the forehead. The second report was dated 06/02/2025, at 4:10 PM, and was written and signed by Caregiver B and Licensee A on 06/02/2025, at 4:30 PM. The report stated, "[Resident 1] was complaining of leg pain when I went to [her/his] room [his/her] pants leg was up I seen a small bruise on the front of [her/his] right foot [sic]." An anatomical diagram accompanied the report, and a pen mark was made on the front of the right ankle.

Police Report

On 06/25/2025, at approximately 2:00 PM, Surveyor reviewed a police report, dated 06/09/2025 and the following was identified:

- Police Officer (PO) E responded to the center where Resident 1 attended adult day program to take a complaint of battery.
- PO E spoke with Resident 1 and Adult Day Care Coordinator (ADCC) C.
- Resident 1 lived at an adult family home (AFH) owned by Licensee A.
- Resident 1 reported on 05/23/2025, s/he attempted to leave the AFH and was stopped by Licensee A who tackled her/him to the ground.
- Resident 1 reported Licensee A struck her/him on her/his right leg, causing bruising.
- Resident 1 reported s/he was not allowed to leave the AFH without supervision.
- PO E observed a bruise to Resident 1's right shin
- PO E documented Resident 1 indicated multiple times s/he did not feel comfortable staying at the AFH and wanted resources to find a new place to live.
- Adult Protective Services (APS) was notified of the allegations.
- PO E interviewed Licensee A.

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- Licensee A denied any physical altercations with Resident 1.
- Licensee A indicated Resident 1 has dementia and becomes confused and had trouble remembering what happened.
- PO E advised Licensee A Resident 1 expressed her/his desire to find new placement and Licensee A told PO E that needed to be done through Aurora Healthcare.

Interviews

On 06/25/2025, at 10:23 AM, Surveyor interviewed Resident 1 and the following was reported:

Surveyor inquired how things were going at the AFH and Resident 1 reported s/he had a friend who was going to talk to a lawyer about "the big [wo/man] beat me up." Resident 1 confirmed Licensee A was who s/he was referring to. Resident 1 reported Licensee A threw her/him down and s/he could not get up. Licensee A would not let go of Resident 1. Resident 1 told Licensee A, "Believe me, I would kill you if I had a gun." Resident 1 reported s/he said that because s/he did not know what to do and was scared. Resident 1's fingers hurt from trying to get up from her/his bedroom floor. S/He had a bruise on her/his right foot/ankle, which s/he showed to Surveyor. Surveyor observed the bruise to be the size of a half dollar. Resident 1 walked slower than usual due to the pain. Resident 1 stated, "This [wo/man] is supposed to help me, not kill me." Resident 1 showed Surveyor a bruise the size of a pea on the top of her/his left hand and stated it was from Licensee A slamming her/his hand in the door. Resident 1 repeated multiple times s/he did not know why this happened and s/he did not create problems. Resident 1 was

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unsure of when the incident occurred.

On 06/25/2025, at approximately 11:00 AM, Surveyor interviewed Licensee A and the following was reported:

On 06/02/2025, Resident 1's day program reported to Licensee A Resident 1 was complaining of pain. Licensee A received a text message from Caregiver B. The following was the content of the text conversation, which was shown to Surveyor by Licensee A on her/his cell phone:

Text Conversation:
- Caregiver B: Sent a picture of a bruise.
- Licensee A replied, "What's that[?]"
- Caregiver B: "Hey [Resident 1] is complaining of leg pain I do see a bruise should I fill out a report [sic][?]"
- Licensee A replied, "Did you ask him where it came from[?]"
- Licensee A: "You can give [her/him] a muscle relaxer[.]"
- Caregiver B: "[S/He] said u [sic] threw [her/him] on the floor[.]"
- Licensee A replied, "I'm on my way they closed the highway [sic][.]"

Licensee A reported s/he called Resident 1's primary care provider (PCP) to discuss if Resident 1 should be seen by her/his PCP following her/his complaints of pain and bruising. S/He reported Advanced Practice Nurse Practitioner (APNP) F told her/him Resident 1 would be fine to come in for her/his regularly scheduled appointment on 07/25/2025.

On 07/02/2025, at approximately 12:15 PM, Surveyor interviewed Licensee A. Licensee A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020376	A. BUILDING: _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEOPLES PLACE (THE)	2330 E CHESTNUT DR OAK CREEK, WI 53154

(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 610	Continued From page 13	M 610		

presented the text message conversation between s/he and Caregiver B, which was part of Resident 1's record. Surveyor took a photograph of the texts at 12:18 PM. Surveyor requested information on Resident 1's bruise and what s/he reported caused the bruising. Licensee A reported an incident report was completed for the bruising. S/He confirmed the incident report did not include detailed information of the report made by Resident 1 to Caregiver B. Licensee A confirmed Resident 1 reported to Caregiver B s/he got the bruises from Licensee A hitting and kicking her/him. Licensee A did not investigate the incident allegation, nor did s/he report the allegation of abuse to anyone to have it investigated.

On 07/10/2025, at 12:15 PM, Surveyor called Resident 1's PCP office and the following information was provided:

- Resident 1's PCP was APNP F.
- There was nothing documented in Resident 1's record indicating Licensee A called to inquire about bringing Resident 1 in to be seen.

On 07/10/2025, at 1:04 PM, Surveyor sent the physician's office a request for records. A second request was made on 07/31/2025, at 1:19 PM. On 07/31/2025, at 4:30 PM, Surveyor received and reviewed the records request sent by APNP F's office. The records provided documented Resident 1 was seen by APNP F on 07/28/2025, for an office visit, follow-up, and behavioral problem. The notes from the office visit indicated Resident 1 was last seen by APNP F on 04/21/2025. The records did not include notes or information Licensee A called to discuss Resident 1's pain or bruising.