STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019288	A. BUILDING: _____ B. WING _____	C 06/17/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS On 06/16/2026 with information gathered through 06/17/2026, Surveyor conducted a complaint investigation, at Guardian Angel Homes 2 LLC, an Adult Family Home (AFH) in Racine, WI. Six deficiencies were identified. Three of the 6 violations are repeat violations, See Statement of Deficiency (SOD) OBDD11, dated 05/10/2023, OBDD12, dated 05/08/2024 and OBDD14, dated 08/14/2025. One of 1 complaint substantiated. Census: 2	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department within 24 hours, when 1 of 1 resident (Resident 1) eloped and was reported missing. Resident 1 eloped from the facility, and the provider did not report to the department.	M 134		

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

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M 134	Continued From page 1 Findings include: On 06/16/2026, Surveyors reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 04/12/2022 with diagnoses including mood disorder, impulse control disorder, dementia and anxiety. -Resident 1 had a guardian. -The consumer roster identified Resident 1 had a managed care organization (MCO) case management team. -Resident 1's MCO case management team case note, dated 05/07/2026, documented the following: "Care Manager (CM) received correspondence from residential provider indicating that member had eloped overnight and had not yet returned. CM called and spoke with provider. Provider indicated that at around 4 am [sic] staff had been in the basement of the home doing laundry. Staff then went upstairs to complete member checks. Staff noted that member was not in [his/her] room. Staff searched the home, and member was not in the house. Staff searched the area around the house and when member was not located the police were notified. Staff updated [Adult Family Home] owner [Licensee A], and upon [his/her] receipt of the message member's [legal guardian] was notified. [Licensee A began searching the local businesses and neighborhoods, as well as contacting local hospitals." -Resident 1's MCO case management team case note, dated 05/08/2026, documented the	M 134		

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M 134	Continued From page 2	M 134		

following: "CM received phone call from Resident 1's legal guardian (LG). LG indicated that member was found earlier in the morning."

-Resident 1's MCO case management team case note, dated 05/08/2026, documented the following: "CM spoke with [Licensee A] to discuss how member was found. [Licensee A] indicated that member was found at 7:52 am [sic] by a former employee of [this facility]. The former employee notified [Licensee A] and brought member back to the home."

On 06/16/2026, Surveyors completed a review of the Department facility folder. Surveyors did not observe any self-reports submitted to the Department in 2026.

On 06/16/2026, at approximately 12:56 PM, Surveyors interviewed Licensee A. Licensee A confirmed s/he did not report Resident 1's elopement to the Department.

On 06/17/2026, Surveyors reviewed Racine Police Department (RAPD) report for incident involving Resident 1 and identified the following:

Incident on 05/07/2026

-On 05/07/2026, RAPD officer responded to this facility for a missing adult.

-"Upon arrival RAPD officer spoke to [Licensee A] whom stated [s/he] was informed from staff member [Caregiver D] this morning that a client [Resident 1] left the residence from approximately 2 am-4 am [sic] when [Caregiver D] was conducting night checks of the residents. [Licensee A] stated [Resident 1] is not known to go outside without supervision of a staff member.

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M 134	Continued From page 3 Dispatch was notified to label [Resident 1] as a missing person."	M 134		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM 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 observation, record review and interview, the provider permitted the existence and continuation of conditions in the home placing the health, safety, and welfare of 2 of 2 at substantial risk of harm. The provider did not implement effective interventions to keep Resident 1 and Resident 2 safe from physical harm to one another. On 06/09/2026, Resident 1 and Resident 2 had a physical altercation in which Resident 1 sustained injuries. Findings include: The facility was licensed on 12/16/2022, as an ambulatory Adult Family Home, which may serve up to 4 residents with advanced aged, developmentally disabled, traumatic brain injury, correctional clients and emotionally disturbed/mental illness. At the time of the survey 2 residents were resided in the facility. On 06/16/2026, at approximately 12:14 PM, Surveyors observed bruise on Resident 1's face under eye and on laugh line left side.	M 230		

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M 230	Continued From page 4 On 06/16/2026, at approximately 12:14 PM, Surveyors interviewed Resident 1. Resident 1 reported someone came into the home drunk and punched [him/her]. On 06/16/2026, at approximately 12:14 PM, Surveyors interviewed Caregiver C. Caregiver C reported that the bruise was not present yesterday. On 06/16/2026, Surveyors reviewed Resident 1's and Resident 2's records and identified the following: Resident 1 -Resident 1 was admitted to the provider's home on 04/12/2022 with diagnoses including mood disorder, impulse control disorder, dementia and anxiety. -Resident 1 had a guardian. -The consumer roster identified Resident 1 had a managed care organization (MCO) case management team. -Resident 1's Behavioral Support Plan, dated 03/01/2026, documented the following: "Description of [Resident 1's] Behavior - [Resident 1] has a history of being verbally and physically aggressive towards staff such as (hitting, kicking, and punching), when [Resident 1] is upset, [s/he] will yell disruptive words, make threats, and be physically aggressive to staff. Current Behaviors - Spitting, eloping, property destruction, physical aggression and stealing things from others. Signs and signals that might occur prior to the behavior - When [Resident 1] is upset, [s/he] will first become verbally aggressive	M 230		

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M 230	Continued From page 5	M 230		

to staff, calling staff names, and making threats towards staff. Staff Response - Staff will attempt to calm, redirect, and encourage [Resident 1] to sit down or go to another room when [s/he] is getting agitated. Staff members will be trained in proper verbal and physical redirecting. DO NOT ENGAGE IN A POWER STRUGGLE THIS WILL MAKE IT WORST [sic]. Specific suggestions for responses to [Resident 1] so [s/he] won't become physically or verbally aggressive - Staff will give [Resident 1] space and block hits when [s/he] is physically aggressive towards staff. Staff will remove all peers from the area when [Resident 1] becomes physically aggressive. How staff can encourage and support more appropriate responses - [Resident 1] staffing pattern is 1:1 for 16 hours a day for 7 days a week, to better accommodate [his/her] needs and attend to [his/her] needs in a timely manner. Personal space should be provided where [s/he] can go. Goals for [Resident 1] to work towards - [Resident 1] will not be aggressive towards [his/her] peers and staff."

-Resident 1's Incident Report, dated 06/09/2026, at 6:50 AM, documented the following: "[Resident 1] [sic] watching [television] until another member [Resident 2] came downstairs. [Resident 1] started calling [Resident 2] names and trying to fight. [Resident 2] tried to go to the back of the [sic] when [Resident 1] started following [him/her] calling [him/her] the [sic] spit in [his/her] face [sic] punched [Resident 2]. [Resident 2] did hit [Resident 1] back. Everything happened really fast, I grabbed [Resident 1], [Resident 2] walked away nothing else happened. [Resident 1] did try to hit me but [sic] got the [sic] from [him/her]. What did you do to make it less painful for the client or to protect the client: By telling [Resident 1] that I 'm here to help just letting [him/her] know

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M 230	Continued From page 6 everything was going to be okay." -Resident 1's Individual Service Plan (ISP), dated 03/01/2026, did not include interventions to keep Resident 1 safe from physical harm by Resident 2. Resident 2 -Resident 2 was admitted to the provider's home on 04/28/2026. -The consumer roster identified Resident 2 had an MCO case management team. -Resident 2's MCO Member Centered Plan, dated 04/23/2026, documented the following: "Mental Health. Diagnosis or concerns: Yes. How are the diagnosis/concerns being addressed: Mood altering [medications]." -Resident 2's record did not contain an ISP. The provider did not implement effective interventions to keep Resident 1 and Resident 2 safe from physical harm to one another. On 06/16/2026, at approximately 1:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed s/he did not implement effective interventions to keep Resident 1 and Resident 2 safe from physical harm by one another. Licensee A reported that the bruises on Resident 1's face were from 06/09/2026 when Resident 1 and Resident 2 got in a fight. Licensee A reported s/he did not get Resident 1 medical attention for the bruises on his/her face. Licensee A reported that s/he did not self-report the resident to resident altercation to the Department or the police.	M 230		

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M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an Individual Service Plan (ISP) was completed and developed within 30 days. This is repeat deficiency. See Statement of Deficiency (SOD) OBDD11, dated 05/10/2023 and OBDD12, dated 05/08/2024. Findings include: On 06/16/2026, Surveyors reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 04/28/2026. -Resident 2's record did not contain an ISP. On 06/16/2026, at approximately 1:20 PM, Surveyors interviewed Licensee A. Licensee A reported s/he did not complete an ISP for Resident 2 due to finding out new things about Resident 2.	M 404		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT	M 420		

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M 420	Continued From page 8 A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) individual service plan (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 1's ISP did not include a signed statement of agreement with all parties involved. This is repeat deficiency. See Statement of Deficiency OBDD14, dated 08/14/2025. Findings include: On 06/16/2026, Surveyors reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 04/12/2022. -Resident 1 had a guardian. -Resident 1's ISP, dated 03/01/2026, was not signed by his/her guardian. On 06/16/2026, at approximately 1:16 PM, Surveyors interviewed Licensee A. Licensee A confirmed Resident 1's ISP was not signed by his/her guardian. Licensee A reported moving forward s/he would ensure all ISPs were signed by all parties.	M 420		

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M 434	Continued From page 9	M 434		
M 434	88.07(1)(e) Supervision The licensee shall arrange for a service provider to be present in the home when the licensee is gone overnight or when the licensee's absence prevents the resident from receiving the services, training or supervision specified in the resident's individual service plan under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for a service provider to be present when 1 of 1 resident's (Resident 1) individual service plan (ISP) indicated that constant supervision was required. On 05/07/2026, Caregiver D left Resident 1 unattended while s/he went in the basement of the home to do laundry. Resident 1 eloped from the facility. Findings include: On 06/16/2026, Surveyors reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 04/12/2022 with diagnoses including mood disorder, impulse control disorder, dementia and anxiety. -Resident 1's ISP, dated 03/01/2026, documented the following: "Safety - Moderate risk or wanders. Desired Outcomes Goals: Will not	M 434		

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M 434	Continued From page 10	M 434		

leave the building unattended. Interventions: Constant supervision of staff, Staff will supervise member at all times when in the community. Desired Outcomes Goals: Safety measures will prevent injury. Interventions: Constant supervision of staff. Desired Outcomes Goals: Will not leave the building unattended. Interventions: Supervise at all times when outside."

-Resident 1's MCO case management team case note, dated 05/07/2026, documented the following: "Care Manager (CM) received correspondence from residential provider indicating that member had eloped overnight and had not yet returned. CM called and spoke with provider. Provider indicated that at around 4 am [sic] staff had been in the basement of the home doing laundry. Staff then went upstairs to complete member checks. Staff noted that member was not in [his/her] room. Staff searched the home, and member was not in the house. Staff searched the area around the house and when member was not located the police were notified. Staff updated [Adult Family Home] owner [Licensee A], and upon [his/her] receipt of the message member's [legal guardian] was notified. [Licensee A] began searching the local businesses and neighborhoods, as well as contacting local hospitals."

-Resident 1's MCO case management team case note, dated 05/08/2026, documented the following: "CM received phone call from legal guardian (LG). LG indicated that [Resident 1] was found earlier in the morning. LG and CM discussed placement options for [Resident 1]."

CM spoke with [Adult Family Home (AFH)] provider [Licensee A] to discuss how [Resident 1]

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M 434	Continued From page 11 was found. Provider indicated that [Resident 1] was found at 7:52 AM [sic] by a former employee of [this facility]. The former employee notified [Licensee A] and brought [Resident 1] back to the home. Upon [Resident 1's] arrival home [his/her] blood sugar was checked and was in the low 200s, which is normal for [Resident 1]. [Resident 1's] legal guardian and law enforcement were notified. [Resident 1] was later taken to the [Emergency Room] by AFH." On 06/16/2026, at approximately 1:00 PM, Surveyors interviewed Licensee A. Licensee A confirmed Resident 1 required constant supervision. Licensee A confirmed Caregiver D left Resident 1 unattended while s/he went in the basement of the home to do laundry. Licensee A reported s/he changed staffing responsibilities, so they do not wash clothes in the basement overnight. That way there will be staff on main levels if Resident 1 wakes up at night. On 06/17/2026, Surveyors reviewed Racine Police Department (RAPD) report for incident involving Resident 1 and identified the following: Incident on 05/07/2026 -On 05/07/2026, RAPD officer responded to this facility for a missing adult. -"Upon arrival RAPD officer spoke to [Licensee A] whom stated [s/he] was informed from staff member [Caregiver D] this morning that a client [Resident 1] left the residence from approximately 2 am-4 am [sic] when [Caregiver D] was conducting night checks of the residents. [Licensee A] stated [Resident 1] is not known to go outside without supervision of a staff member. Dispatch was notified to label [Resident 1] as a	M 434		

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M 434	Continued From page 12 missing person." According to the Weather Underground. com website, the temperatures for 05/07/2026 ranged from a maximum of 50 degrees F to a minimum of 35 degrees F at 4:53 AM. The temperatures for 05/08/2026 ranged from 32 degrees F at 4:53 AM and climbed to approximately 47 degrees F by 7:53 AM. Resident 1 was exposed to freezing temperatures while absent from the home during this incident. CROSS REFERENCE M 134 88.03(5)(e)1 - Significant Change To The Resident	M 434		
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 3) prescription medications were securely stored. Resident 3's prescription medications were located on the dining room table.	M 458		

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M 458	Continued From page 13 This is repeat deficiency. See Statement of Deficiency (SOD) OBDD11, dated 05/10/2023 and OBDD12, dated 05/08/2024. Findings include: On 06/16/2026, at approximately 12:28 PM, Surveyors observed the following: Resident 3's prescription medications were located on the dining room table which contained the following medications: -Propranolol 10 milligram (mg) tablet (60 pills) -Fluoxetine 20 mg capsule (30 pills) -Ramelteon 8 mg tablet (30 pills) -Guanfacine 1 mg extended-release tablet (30 pills) -Amlodipine 5 mg tablet (30 pills) -Rosuvastatin 5 mg tablet (30 pills) On 06/16/2026, at approximately 12:28 PM, Surveyors interviewed Caregiver B and Caregiver C. Caregiver B and Caregiver C confirmed the medications were on the dining room table all day so Licensee A can destroy them. Caregiver B and Caregiver C reported that medications belonged to a previous resident (Resident 3).	M 458		