STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018744	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVED BY GRACE FAITH ADULT FAMILY HOM	3845 NORTH 10TH STREET MILWAUKEE, WI 53206

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M 000	INITIAL COMMENTS On 07/23/2026, Surveyor completed a complaint investigation at Saved By Grace Faith Adult Family Home LLC. As a result, 2 deficiencies were identified and 1 complaint was substantiated Census: 3	M 000		
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 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 identify or reassess 1 of 1 resident's (Resident 1's) needs following her/his return to the facility after a 22-day hospital stay resulting in another elopement and Resident 1's death.	M 424		

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

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M 424	Continued From page 1 Findings include: On 07/09/2026, the Department received a complaint alleging concerns with resident supervision. Record Review On 07/09/2026, Surveyor reviewed Department records and reviewed a self-report received 07/08/2026. The report indicated Resident 1 was aggressive, appeared to be responding to internal stimuli, and hallucinating on 07/07/2026. Resident 1 then eloped from the facility and law enforcement was contacted. On 07/09/2026, at approximately 7:30 AM, Surveyor reviewed Resident 1's record emailed by Licensee C at 7:26 AM on 07/09/2026. Resident 1 was admitted on 04/27/2026. Resident 1's individual service plan (ISP), dated 04/27/2026, was incomplete and did not identify her/his behaviors, supervision, or inform staff Resident 1 had a behavior support plan (BSP), dated 05/29/2026. The supervision and behavioral intervention areas were not filled out in Resident 1's ISP. The ISP indicated the following: "... Behavioral Intervention Is any teaching or redirection required by the [Adult Family Home] provider? Please Specify... ...Supervision Member requires twenty-four-hour supervision (cannot be left alone). YES NO Member can spend _____ hours at a time unsupervised. Member can come and go from the [Adult Family Home] AFH as they desire.	M 424		

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M 424	Continued From page 2 Comments....." Resident 1's BSP, dated 05/29/2026, indicated the following: "... STAFFING RECOMMENDATION 1:1 Dedicated Behavioral Supervision / Enhanced Support 24 Hours Per Day, 7 Days Per Week... [Resident 1] has a significant history of elopement and remains a high flight risk...." Resident 1's file contained a member-centered plan from her/his managed care organization (MCO), dated 11/01/2025, which indicated the following: "... Behaviors Requiring Intervention Wandering/Elopement: Yes Describe Behaviors: Member will elope and run from AFH without warning Self-Injurious Behaviors: Yes Describe Behaviors: Member will bang her/his head on hard surfaces when upset or frustrated. Offensive/ Violent Behaviors: The member has property destruction behaviors, will hit, punch, kick, bite, and throw objects at others. Other Behaviors: No Member has a BSP: Yes..." On 07/22/2026, at approximately 10:30 AM, Surveyor reviewed Resident 1's file located in the facility. Resident 1's file contained a form titled "Client Rights Limitation Or Denial Documentation", dated 05/27/2026, which indicated the following: "...Describe Specific, Individualized Limitation/Denial: Saved By Grace staff will provide 1:1 dedicated staffing for the member	M 424		

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M 424	Continued From page 3 24/7. Staff will remain directly outside the bathroom with the door open enough so visibility can be maintained during bathing and toileting tasks. Staff will assist the member directly with tasks as needed including verbal cues and hands on assistance. Staff will monitor the need for redirection.... Reason for Limitation/Denial - Safety - Member may elope. Mbr [sic] also has behaviors including property destruction, physical aggression and threats of self-harm. Staff need to maintin [sic] line of sight supervision to ensure member does not injure her/himself or destroy the bathroom." Resident 1's file contained incident reports which identified the following: 05/16/2026, at 4:30 PM entered by Caregiver B. - Staff and residents were outside the facility. Resident 1 went into the facility alone. When Resident 1 did not return to the group outside, staff entered the facility to locate her/him. Staff looked for Resident 1 for "hours" but did could not locate her/him. A missing person report was filed with the local police department. The report did not indicate when Resident 1 was found and returned to the facility. 05/29/2026, at 9:00 PM, titled "Runaway Resident" entered by Caregiver D - Resident 1 walked outside with another resident. When staff attempted to bring residents into the facility, Resident 1 walked into the facility and then ran out of the facility through the back door. The report did not indicate when Resident 1 was found and returned to the facility. 06/14/2026, at 4:00 PM entered by Caregiver B - While staff member on duty utilized the bathroom, Resident 1 eloped from the facility.	M 424		

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M 424	Continued From page 4 Staff attempted to locate Resident 1 but were unsuccessful. Police were notified at approximately 4:19PM. The incident report contained a police contact card dated 06/14/2026 at 5:11 PM. Resident 1's After Visit Summary (AVS), dated 07/06/2026, identified Resident 1 was admitted to the hospital for neurological intensive care from 06/15/2026 through 07/06/2026. Resident 1's AVS stated, "Reason for Hospitalization...Your primary diagnosis was: Breakthrough Seizure...Your diagnoses also included: Elevated Troponin, Intractable Generalized Idiopathic Epilepsy Without Status Epilepticus, Psychiatric Disorder, Intellectual Disability..." Resident 1's record did not include any assessments of the elopements or following his/her 22 day hospital stay. Interview On 07/09/2026, at approximately 3:30PM via telephone, Surveyor interviewed Licensee C. Surveyor requested updates on Resident 1's status after the self-report was sent to the Department. Licensee C reported s/he was informed by the local police department Resident 1 was killed when s/he was struck by a motor vehicle on the morning of 07/08/2026. Licensee C reported prior to Resident 1's return to the facility, s/he required additional medication and restraints during her/his hospital stay. Licensee C reported Resident 1 returned to the facility on 07/06/2026 in the afternoon and eloped again on 07/07/2026 at approximately 11:25 PM. Licensee C confirmed Resident 1's ISP and BSP were not updated prior to, or after Resident 1's return to the facility. Licensee C emailed Surveyor Resident 1's	M 424		

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M 424	Continued From page 5 current ISP and BSP, behavior notes, hospital records, and documentation of phone calls to Resident 1's case managers. On 07/22/2026, at approximately 11:30 AM, Surveyor interviewed Caregiver A. Caregiver A reported Resident 1 required restraints throughout her/his inpatient hospital stay. Caregiver A reported Resident 1 was returned to the facility on 07/06/2026 via 2 ambulances and 4 emergency medical technicians. Caregiver A reported Resident 1 was in restraints when s/he was returned to the facility. On 07/22/2026, at approximately 10:00 AM, Surveyor interviewed Licensee C at the facility. Licensee C again confirmed the ISP and BSP in Resident 1's file were not updated or changed after her/his return to the facility. Licensee C reported the files were not updated because Resident 1 was only in the facility for 1 day. On 07/23/2026, at approximately 2:00 PM, Surveyor interviewed Licensee C via telephone. Surveyor inquired again if Licensee C assessed Resident 1 prior to her/his return to the facility. Licensee C reported s/he did not reassess Resident 1 but was aware s/he required restraints during her/his hospital stay. Licensee C reported s/he contacted Resident 1's legal guardian and case managers the next morning after Resident 1 returned and explained s/he was displaying the same behaviors. Licensee C reported s/he expressed her/his concerns that Resident 1 was not suitable for placement in the facility. Surveyor inquired if any changes were discussed, planned, or implemented after the phone call, Licensee C reported "I did not have a chance to make the changes". Surveyor informed Licensee C s/he could email any further documentation s/he had,	M 424		

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M 424	Continued From page 6 Licensee C reported that "it is what it is...if it isn't going to remove the cites what is the point".	M 424		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 1 resident (Resident 1) received prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 did not receive her/his nighttime medications on 07/07/2026 as prescribed by her/his physician. Findings include: On 07/22/2026, at approximately 10:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/27/2026. Resident 1's record contained a medication administration record (MAR) dated "July 2026 Night Meds". Resident 1's MAR indicated Resident 1 was prescribed gabapentin 300 milligram (mg) capsule: take 1 capsule twice a day, lacosamide 100 mg tablet, take one tablet by	M 582		

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M 582	Continued From page 7	M 582		

mouth twice a day, ziprasidone hydrochloride (HCL) 80 mg capsule: take 1 capsule twice a day, and divalproex sodium 250 mg tablet: take five tablets twice a day. The MAR indicated Resident 1 received her/his night time medications on 07/06/2026, as evidenced by staff initials, when s/he returned to the facility after being discharged from the hospital with the medications. No initials were observed for Resident 1's nighttime medications on 07/07/2026. Surveyor did not locate any evidence which indicated Resident 1 refused her/his medication on 07/07/2026.

Surveyor counted Resident 1's remaining medication and identified the following:

Gabapentin 300 mg (30 prescribed) - 30 remaining
- Documented as given on 07/06/26

Divalproex sodium 250 mg (150 prescribed) - 145 remaining
- One dose documented as given on 07/06/2026

Lacosamide 100 mg (30 prescribed) - 29 remaining
- One dose documented given on 07/06/2026

Ziprasidone HCL 80 mg (30 prescribed) - 29 remaining
- One dose given on 07/06/2026

On 07/22/2026, at approximately 10:10 AM, Surveyor interviewed Caregiver B. Caregiver B confirmed s/he was working on 07/07/2026 and was Resident 1's dedicated 1:1 caregiver. Caregiver B reported Resident 1 was aggressive, hallucinating, and attempted to open her/his window on multiple occasions on 07/07/2026. Caregiver B reported s/he "did not recall" if

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M 582	Continued From page 8 Resident 1 took her/his meds. On 07/22/2026, at approximately 11:35 AM, Surveyor interviewed Caregiver A. Caregiver A reported s/he believed Resident 1 took her/his nighttime medications on 07/07/2026. Caregiver A reported it was her/his and Caregiver B's responsibility to pass nighttime medications on 07/07/2026. Surveyor inquired why the medications were not documented as given. Caregiver A reported s/he believed staff forgot to document the medication as given. Caregiver A then reported s/he documented the medications on the wrong MAR. Surveyor informed Caregiver A, after counting Resident 1's medications, s/he could not have received her/his divalproex sodium, lacosamide, or ziprasidone, because only one dose was removed from each container (accounted for from the 07/06/2026 nighttime med pass). Caregiver A did not offer further explanation. Summary Resident 1 did not receive her/his gabapentin, divalproex sodium, lacosamide, or ziprasidone as prescribed by her/his physician on 07/07/2026 before s/he eloped from the facility.	M 582		