STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 07/28/2025, with information gathered through 07/30/2025, Surveyor conducted a standard licensure survey. Four deficiencies were identified. 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 provided in this chapter or in ch. 50,	M 114		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 114	Continued From page 1 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 2 personnel files reviewed included a complete background check as required. The report from the Department of Justice (DOJ) criminal record and the Integrated Background Information System Letter (IBIS) was not completed when Caregiver E documented that s/he had lived out of the state in the last 3 years. Findings include: The provider was licensed to serve up to 4 ambulatory individuals with a primary diagnosis that includes but not limited to: Developmentally Disabled, Emotionally Disturbed/Mental Illness, Irreversible Dementia/Alzheimer's, Traumatic Brian Injury, Advanced Age. On 07/28/2025 at 3:23 PM, Surveyor requested Caregiver E's employment record from Licensee A. On 07/30/2025, Surveyor reviewed Caregiver E's record. Caregiver E was hired on 12/19/2024 and his/her employee file included the following background information:	M 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 114	Continued From page 2 Background Information Disclosure (BID) form, dated 12/19/2024, documented that Caregiver E had lived in Missouri from 2018 to 2024. DOJ report, dated 12/19/2024. IBIS letter, dated 12/19/2024. Surveyor noted an additional background check should have been completed for the state of Missouri. On 07/30/2025, at approximately 2:00 PM, Surveyor interviewed Manager B. Manager B stated that Caregiver E had resided in Missouri due to military obligations and did not complete the out-of-state background check.	M 114		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility	M 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 262	Continued From page 3 appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview the provider did not ensure that access within the home was provided for a resident who was unable to ambulate without the use of a walker. The bedroom and bathroom doors serving the resident did not have a clear opening of 32 inches. Findings include: The provider was licensed to serve up to 4 ambulatory individuals with a primary diagnosis that includes but not limited to: Developmentally Disabled, Emotionally Disturbed/Mental Illness, Irreversible Dementia/Alzheimer's, Traumatic Brian Injury, Advanced Age. On 07/28/2025, at approximately 11:50 AM, Surveyor arrived at the home and observed Resident 1 sitting at the kitchen table, with his/her walker. On 07/28/2025, at approximately 12:50 PM, Surveyor observed Resident 1's room. Surveyor was unable to open the door all the way, due to it being blocked by a chair. Surveyor opened the doorway halfway, walked in, moved the chair and then proceeded to measure the doorway, which measured at 29 ½ inches. Surveyor then measured the resident's bathroom doorway, which measured 29 ¾ inches at entrance, and 28 ½ inches between doorhandle and wall. On 07/28/2025, Surveyor reviewed Resident 1's record.	M 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 262	Continued From page 4 Resident 1 moved into the home, 12/11/2023, with diagnosis including Chronic Obstructive Pulmonary Disease (COPD). Resident 1's "Individual Support Plan/Care Plan," dated 06/2025, documented: "[S/he] uses a walker for mobility." "[Resident 1] is using a walker to stabilize [his/her] balance when out in the community and when navigating in the home. [Resident 1] needs a standby assist when entering/leaving a car and when entering the house." Resident 1's "Assisted Living Facility Waiver, Approval, Variance or Exception Request," dated 12/11/2023, documented: "Resident uses walker temporarily when for support and balance while walking in the home and in the community. Resident is currently having two physical therapy sessions every week." The request was approved, with an expiration date of 06/11/2024. On 07/28/2025, at approximately 1:00 PM, Surveyor overheard Resident 1 speaking with Caregiver C, explaining that s/he had knee concerns which limited his/her mobility. On 07/30/2025, at approximately 2:00 PM, Surveyor interviewed Manager B. Surveyor discussed the environmental requirements regarding non-ambulatory residents. Manager B stated that the environmental concern of ramping the secondary exit, would be considered so that Resident 1 could remain in the home.	M 262		
M 276	88.05(3)(a) Homelike Environment	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 276	Continued From page 5 An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe, homelike environment appropriate for residents' needs. Findings include: The provider was licensed to serve up to 4 ambulatory individuals with a primary diagnosis that includes but not limited to: Developmentally Disabled, Emotionally Disturbed/Mental Illness, Irreversible Dementia/Alzheimer's, Traumatic Brian Injury, Advanced Age. On 07/28/2025, at approximately 11:50 AM, Surveyor toured the home and determined that the home seemed warm. Surveyor observed the thermometer hanging on the wall which read 78 degrees Fahrenheit. Surveyor observed the thermostat on the wall which read 76 degrees Fahrenheit. Surveyor temped the room air with his/her thermometer which read 76.8 degrees Fahrenheit. Surveyor commented to Caregiver C that the home felt warm. Caregiver C stated that the upstairs of the home was kept warmer, otherwise Resident 3's room, which was in the basement, would become very cold. On 07/30/2025, at approximately 2:00 PM,	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 276	Continued From page 6 Surveyor discussed the concern with Manager B. Manager B stated that, based on those temperatures, the home was too warm and would be discussing the concern with staff.	M 276		
M 326	88.05(3)(n)1 BED-CLEAN, GOOD CONDITION, PROPER SIZE A separate bed for each resident unless a couple chooses to share a bed. The bed shall be clean, in good condition and of proper size and height for the comfort of the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a bed was clean and in good condition for 1 of 1 resident (Resident 1). Findings Include: The provider was licensed to serve up to 4 ambulatory individuals with a primary diagnosis that includes but not limited to: Developmentally Disabled, Emotionally Disturbed/Mental Illness, Irreversible Dementia/Alzheimer's, Traumatic Brian Injury, Advanced Age. On 07/28/2025, at approximately 12:40 PM, Surveyor observed Resident 1's bedroom. Surveyor observed Resident 1's bed, which did not contain sheets on the mattress, but contained a plastic sheet that was too large for the bed. The sheets were rolled up into a ball and lying on the corner of the mattress. Surveyor determined the mattress was half the thickness of the box springs. Surveyor pressed down on the mattress and was able to easily feel each spring in the	M 326		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 326	Continued From page 7 mattress. On 07/28/2025, at approximately 4:50 PM, Surveyor interviewed Resident 1's Guardian D. Guardian D explained that s/he had not been informed that Resident 1 required a new mattress. On 07/30/2025, at approximately 2:00 PM, Surveyor interviewed Manager B. Surveyor discussed the observation. Manager B stated Resident 1 preferred to lay on the plastic. Surveyor stated that Guardian D was not aware that Resident 1's mattress needed to be replaced. Manager B stated s/he would contact Guardian D.	M 326		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 332	Continued From page 8 and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that fire extinguishers were inspected annually. Findings include: The provider, who was licensed 08/17/2021, can provide cares for up to 4 residents in the client groups: advanced aged, emotionally disturbed/mental illness, traumatic brain injury, irreversible dementia/Alzheimer's, and developmentally disabled. On 07/28/2025, at approximately 12:45 PM, Surveyor toured the home and observed that 2 of 2 fire extinguishers were last serviced 03/2024. On 07/30/2025, at approximately 2:00 PM, Surveyor interviewed Manager B. Manager B stated the fire extinguishers had been serviced in 10/2024. On 07/30/2025 at 5:26 PM, Surveyor emailed Manager B a picture of the fire extinguisher tag which displayed the last service date of 03/2024.	M 332		
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	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018579	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ADULT FAMILY HOME LLC 2	3009 MUIR FIELD ROAD MADISON, WI 53719

(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 346	Continued From page 9 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 ensure 2 of 2 residents reviewed were evaluated annually for evacuation time, using the departments form. Resident 1's evacuation evaluation was not completed in 2025. Resident 3's evacuation evaluation was not completed in 2023 and 2024. Findings include: On 07/28/2025, Surveyor reviewed Resident 1's and Resident 3's record. Resident 1's annual evacuation assessment was dated 05/14/2024. There was no documentation indicating Resident 1 had been evaluated in 2025. Resident 3's annual evacuation assessment was dated 03/23/2022. There was no documentation indicating Resident 3 was evaluated annually in 2023, 2024, and 2025. On 07/30/2025, at approximately 2:00 PM, Surveyor interviewed Manager B. Manager B stated there was a breakdown in understanding of the requirement. Manager B stated, "We thought it only had to be updated if there was a change." Manager B stated s/he would review all resident files to ensure their evacuation assessments had been reviewed.	M 346		