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	0016594	A. BUILDING: _____ B. WING _____	R-C 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BETTER WAY ADULT FAMILY HOME LLC	1512 S UNION ST MILWAUKEE, WI 53204

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{M 000}	INITIAL COMMENTS On 02/05/2026 with information gathered through 02/10/2026, Surveyor conducted a verification visit for SOD 8XOW11, dated 05/16/2025 and two complaint investigations, at A Better Way Adult Family Home LLC, an Adult Family Home (AFH) in Milwaukee, WI. Five deficiencies were identified. Two of the 5 deficiencies were repeat deficiencies from Statement of Deficiency 8XOW11, dated 05/16/2025. Two of 2 complaints unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a description of the services in the individual service plan (ISP) the licensee would provide to meet the assessed needs of 2 of 2 residents (Resident 2 and Resident 3). Resident 2's ISP did not include information regarding how staff were to manage Resident 2's behaviors. Resident 3 had a history of substance	M 412		

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

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use. Resident 3's ISP did not address Resident 3's substance use.

Findings include:

On 02/05/2026, Surveyor reviewed Resident 2's and Resident 3's records and identified the following:

Resident 2
-Resident 2 was admitted to the provider's home on 08/12/2020, with diagnoses including bipolar disorder and schizophrenia.

-Resident 2's staffing case notes, dated 10/01/2025, documented the following:

"1st shift: Upon arrival [Resident 2] is watching TV music videos in the living room. For breakfast ate scrambled eggs w/bread, fruits & drank 1 cup of milk. Ate 100% of the meal. Clean up & wash hands. Gave meds as schedule & offers water frequently. Return to watch TV shows, talks to [him/herself], when taking [Resident 2] for a walk to the front porch tend to tell any stranger that [s/he] wants to [sic] to their bed to sleep w/them laughing, repeats sexual things, constantly falling asleep standing & sitting down with [his/her] head tilted down [his/her] back is bending w/time, stumbling w/the wall & dragging feet when walking. Hitting [him/herself] w/the wall leaving a small scratch. Use restroom as needed & wash hands. Refuse to do a BM, staining [sic] pull up 3x, spending [his/her] time doing tantrums yelling & using bad words [sic] staff. For lunch ate at 12 pm tacos w/rice, fruits & drank 1 cup of water. Ate 100% of the meal. Cleaning up & wash hands. Return to watch TV in the living room, does a lot of pacing around the house, interacting w/peers, [s/he] requested to watch a movie. Went to the

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back patio for 2 [hours] saying sexual things when seen a [wo/man] passing by. Ate yogurt for snacks. Constant reminder & a lot of redirection. Behaviors are constant. [Resident 2] drank 3 cups of water during shift. Last check 2:45 pm is in the kitchen asking for food."

"2nd shift: Upon arrival [Resident 2] is in the kitchen demanding food repeating [s/he] haven't ate all day manipulating the staff. Cries & does tantrums, goes to the wall & says [s/he] gets abused & was being pushed through the stairs. Does a lot of pacing around, hearing voices, talks to [him/herself], talking to the wall making signs w/hands, repeating staff pull hair, cries, constantly watching through the window. All meds given as schedule & offer water frequently and [s/he] rejected to drink throwing it in the floor. Use restroom as needed & wash hands. Refuse to do a BM, constantly standing doing tantrums & cries. At 4:45 pm ate chicken pasta w/veggies, fruits & drank 1 cup of juice. Ate 100% of the meal. Clean up & wash hands. Return to walk & went to the back patio for 2 [hours] to do activities. Ate cookies for snacks. Demanding food yelling & insulting staff constantly entering to [sic] the kitchen opening refrigerator. Constantly making false accusation & threatening staff that [s/he] could tell [his/her] family we abused [him/her] if [sic] don't give [him/her] sweets. Constant redirection & a lot of reminders. Behaviors are constant. During shift [Resident 2] drank 3 cups of water. At 8 pm gave meds as schedule, use restroom & wash hands, brush teeth, put pajamas on & went to lay down to sleep at 8:35 pm. Tendency on moving clothes forgets where [s/he] place them & blames staff, kept turning the lights on, asking for food, using restroom frequently as an excuse & arguing w/peers. Falling asleep at 10 pm. Last check at 10:45 pm

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is asleep, snoring in observation no concerns."

-Resident 2's staffing case notes, dated 11/07/2025, documented the following:

"2nd shift: Upon arrival [Resident 2] been sitting down watching TV. Walks to the kitchen gets near the stove demanding food yells & insults staff. When redirecting [him/her] away refuse. [Resident 2] has a small scratch on [his/her] forehead, says [s/he] probably did it sleeping, then [s/he] said [s/he] probably hit [him/herself] w/the wall. Can't remember anything changing [him/her] stories frequently. Does a lot of pacing around the house, looking through the window, talks to [him/herself], hearing voices, demands food insulting staff frequently, repeating staff hit [him/her], making signs w/hands talking to the wall & TV screen. Gave meds as schedule & offer water frequently. Use restroom as needed & wash hands. Refuse to do a BM, in [his/her] desperation cries & does tantrums. For dinner ate at 4:45 pm chicken, rice, beans, morzilla [sic], fruits drank & 1 cup of juice. Ate 100% of the meal. Clean up & wash hands. Return to do activities does a lot of pacing, painted & painted nails. Watch TV shows & ate chips for snacks. [Resident 2] drank 3 cups of water during shift. At 8 pm gave meds as scheduled, use restroom & wash hands, put pajamas on, brush teeth & went to lay down in bed at 8:30 pm. Turning the lights on, arguing w/peers & demanding food. Falling asleep at 9:42 pm. Last check 10:45 pm is asleep in observation no issues or concerns to report in [sic] shift."

-Resident 2's staffing case notes, dated 11/08/2025, documented the following:

"1st shift: Upon arrival [Resident 2] is in the living

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room watching TV. For breakfast ate peanut butter sandwich w/jelly, fruits w/yogurt & drank 1 cup of water. Ate 100% of the meal. Clean up & wash hands. Gave meds a schedule & offer water frequently. Return to the living room to watch TV, nap for 1 [hour], when walking drag feet with [his/her] head tilted down stumbling w/the wall, talks to [him/herself], hearing voices, making signs w/hands talks to the wall, looking through the window & repeating [s/he] is leaving w/ [sibling]. Constantly pulling [his/her] pants down to check & touch [his/herself] for no reason. Kept closing [his/her] right eye for no reason. Use restroom as needed & wash hands. Constantly standing refuse to do a BM, spending [his/her] time doing tantrums & crying. For lunch ate at 12 pm pasta chicken Alfredo, fruits & drank 1 cup of juice. Ate 100% of the meal. Clean up & wash hands. Return to watch TV, went to the back patio for 20 min & painted for 10 min. Any activities staff tries to do with [Resident 2] [s/he] refuse, wants to be sitting down all day watching TV. [Resident 2] ate fruits for snacks. Drank 2 cups of water during shift. Last check 2:45 pm is watching TV w/peers demanding food, calling [sibling] [sic] [s/he] haven't ate all day."

-Resident 2's staffing case notes, dated 12/12/2025, documented the following:

"2nd shift: Upon arrival [Resident 2] is watching TV, cursing, making lies & assumptions trying to manipulate staff. All meds given as schedule & offering water frequently. Use restroom as needed & wash hands. Gets impatient keep getting up from the toilet sit, refuse to do a BM, staining pull up. Constantly watching outside through window, interacting w/peers, watch TV, hearing voices, talks to [him/herself], making sign w/hands talking to the wall, calling [her/her]

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[sibling] that [s/he] gets hit just because staff denied [his/her] sweets until dinner, doing tantrums & cursing. At 5 pm ate potato soup w/chicken, fruits & drank 1 cup of water. Ate 100% of the meal. Brush teeth & clean up. Spilling food & water in [sic] the table & floors. Staff had to finish feeding. Return to the living room, refuse to do activities, everything upset [him/her] only does a lot of pacing around the house. Pulling [his/her] pants down in front of the peers says [s/he] felt something wet touching & checking [him/herself]. Closing right eye for no reason. Constant redirection & a lot of reminders. Behaviors are constant. For snacks ate chips. During shift drank 2 cups of water. At 8 pm gave meds as schedule, use restroom & wash hands, brush teeth, put pajamas on & went to lay down to sleep at 8:45 pm. Moving clothes, arguing, yelling at staff & using restroom as an excuse not to sleep. Falling asleep at 10 pm. Last check at 10:45 pm is asleep checking breathing & body temperature no issues or concerns."

-Resident 2's staffing case notes, dated 12/18/2025, documented the following:

"2nd shift: Upon arrival [Resident 2] is watching TV w/peers. Kept arguing w/one of the peers, insulting each other calling them names. Making residents upset to the point they confronted [him/her] upfront resident kept crying. Hearing voices, talks to [him/herself], making signs w/hands talking to [him/herself], cries. Tend to pull pants says [s/he] feels wet & kept checking & touching [him/herself]. Calling [sibling] through the window to bring [him/her] cake, purses & pizza. Use restroom as needed & wash hands. Gets very impatient kept standing refuse to do a BM, spending [his/her] time doing tantrums & crying. Demanding toilet paper after receiving

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assistance. Gave meds as schedule & offer water frequently. At 5 pm ate dinner chicken enchiladas, fruits & drank 1 cup of water. Ate 100% of the meal. Clean up & wash hands. Return to walk, danced, sang & nap for 23 min. Ate a pudding cup for snacks. Threatening staff if they don't give [him/her] sweets [s/he] [sic] staff. Then [s/he] says [s/he] was only joking around. Constant reminders & a lot of redirection. Behaviors are constant. [Resident 2] drank 3 cups of water during shift. At 8 pm gave meds as schedule, use restroom & wash hands, brush teeth, put pajamas on & went to lay down to sleep at 8:45 pm. Arguing w/peers, disorganizing clothes & demanding food. Falling asleep at 9:48 pm. Last check 10:45 pm is asleep in observation no issues or concerns to report in shift."

-Resident 2's staffing case notes, dated 01/04/2026, documented the following:

"2nd shift: Upon arrival is reported by staff [Resident 2] is out facility & arrived at 6:41pm. Was very excited telling staff [s/he] ate Puerto Rican food & drank 1 milkshake. Watch TV, arguing w/peers. Talks to [him/herself], hearing voices, talking to the wall making signs w/hands, arguing w/peers threatening to hit them, then says [s/he] got hit cries making watch TV & listen to music. At 8 pm gave meds, use restroom & wash hands, brush teeth, put pajamas on & went to lay down to bed at 8:45 pm. Tendency to moved clothes, arguing w/peers, [s/he] said can't sleep. Constantly using the restroom. Falling asleep at 10 pm. Last check at 10:45 pm is asleep, snoring in observation no more issues."
-Resident 2's staffing case notes, dated 01/13/2026, documented the following:

"2nd shift: Upon arrival [Resident 2] is watching

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TV. Behaviors are constant. Pacing around the house, yelling & insulting staff, constantly watching outside through window, interacting w/peers, watch TV, hearing voices, talks to herself, making signs w/hands talking to the wall, sang & danced. Constantly pulling [his/her] pants down in front of peers says [s/he] feels wet, checking & touching [him/herself]. All meds given as schedule & offering water frequently. Use restroom as needed & wash hands. Gets impatient keep standing from toilet sit, refuse to do a BM, spending [his/her] time crying. Wants to wipe [him/herself] w/anything [s/he] finds, refuse to let things go. At 4:30 pm ate hot dogs w/veggies, ice cream & drank 1 cup of juice. Ate 100% of the meal. Clean up & wash hands. Return to do exercise, does a lot of pacing around the house, painted nails & danced. For snacks ate chips. [Resident 2] drank 2 cups of water during shift. At 8 pm gave meds as schedule, use restroom & wash hands, brush teeth, put pajamas on & went to lay down to sleep at 8:45 pm. Turning the lights on, moving clothes not letting peers sleep & using restroom as an excuse, refusing to go back to bed. Falling asleep at 10 pm. Last check 10:45 pm is asleep in observation no issues or concerns to report during shift everything is fine."

-Resident 2's staffing case notes, dated 02/01/2026, documented the following:

"2nd shift: Upon arrival [Resident 2] is in the kitchen demanding food insulting staff verbally. Tried to touch hot food on top of the stove & when redirecting [him/her] away refuse & cries. Return to the living room, talks to [him/herself], hearing voices, making signs w/hands talking to the wall & TV screen, looking through the window, pulling [his/her] pants down for no reason touching &

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checking [his/herself]. All meds given as schedule & offer water frequently. Use restroom as needed & wash hands. Constantly standing from toilet sit, staining [his/her] pull up refuse to do a BM, spending [his/her] time [sic]. At 4:30 pm ate dinner chicken enchiladas, fruits & drank 1 cup of water. Ate 100% of the meal. Clean up & wash hands. Return to walk, watch TV, pacing around the house & painted for 10 min. Ate jello for snacks. Demands food insulting staff repeating [s/he] haven't [sic] ate all day cries. Constant redirection & a lot of reminders. Behaviors are constant. Drank 2 cups of water during shift. At 8 pm gave meds as schedule, use restroom & wash hands, brush teeth, put pajamas on & went to lay down to sleep at 8:35 pm. Tendency on moving clothes forgets where [s/he] place [sic] them & blames staff, kept turning the lights on, asking for food & arguing w/peer. Falling asleep at 10:21 pm. Last check at 10:45 pm is asleep in observation no issues or concerns to report during shift."

-Resident 2's staffing case notes, dated 02/04/2026, documented the following:

"1st shift: Upon arrival [Resident 2] is watching TV & demanding food. Gave meds as schedule & offering water frequently. For breakfast ate oatmeal w/fruits mix & drank 1 cup of milkshake. Ate 100% of the meal. Clean up & wash hands. Helped w/shower & did all ADLs. Return to the living room watch TV & pacing around the house, hearing voices, talks to [him/herself], constantly looking through the window, insulting staff for everything, repeating [s/he] [sic] leaving to the store, nap for 40 min, cries. Use restroom as needed & wash hands. Refuse to do a BM, constantly standing yelling & insulting staff. When walking drag feet with [his/her] head tilted down

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stumbling w/chair. For lunch ate sandwich w/veggies, cookies & drank 1 cup of water. Ate 100% of the meal. Clean up & wash hands. Return to watch TV, staff painted nails & drew for 10 min gets tired & refuse to do activities. Any activities staff tries to do with [him/her] [sic] refuse, wants to be sitting down all day watching TV. At 2:50 pm remain watching TV w/peers."

-Resident 2's ISP, dated 01/28/2026, documented the following:

"Mental and Emotional Health: Symptoms/diagnosis of mental illness: [Resident 2] has been diagnosed with a mental illness. Will display moods of some verbal aggression with staff and asking for food frequently at times. Behavior Patterns: Presence of patterns that may be harmful to self or others including destruction of property: [Resident 2] is not harmful while on medications, [Resident 2] can become aggressive without medication management. Coping patterns including unusual responses, scheduling preferences related to meals, sleep, ADLs: Redirection may be needed. Behavior Patterns: [Resident 2] has several mental diagnosis [sic] and will be monitored closely for changes in behavior patterns. Resident Goal/Desired Outcome with Time Limits for Attainment: [Adult Family Home] will monitor all behavior patterns, [Resident 2] will be redirected whenever needed, and report any changes to, Mental Health Professional, and [Managed Care Organization]."

Resident 2's ISP did not include information regarding how staff were to manage Resident 2's behaviors.

Resident 3

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-Resident 3 was admitted to the provider's home on 02/05/2024.

-Resident 3 had the following diagnosis: substance use.

-Resident 3's staffing case notes, dated 08/09/2025, documented the following:

"2nd shift: Upon arrival is reported by staff [Resident 3] is out facility & arrived at 6:40 pm. [Adult child] drop [him/her] off at the back patio sitting down smoking. Staff went to check on [him/her] & [Resident 3] was talking very slow & when standing was very dizzy. Staff notify owner immediately. Had a bruise [sic] [his/her] right elbow & leg, use restroom twice & throw up. [Resident 3] lose balance & was falling on top of the table. Refusing assistance. Notify owner. Ambulance arrived at 7:21 pm was upset refusing help & stumbling. At 7:46 pm [sic] [his/her] own term [sic] on going w/the ambulance. Notify owner, call ambulance, chart notes & wrote incident report. [Resident 3] arrived at 9:45 pm was very wet, stumbling when walking, refuse to receive help from staff since it was raining. [Resident 3] entered to the facility yelling & insulting staff verbally calling them through names. Refuse to take a shower to avoid getting sick staff helped to change clothes into [his/her] pajamas, use restroom & wash hands, brush teeth, did all ADLs & return to bedroom. Complaining about the resident [s/he] shares room with & arguing. Falling asleep at 10:34 pm. Last check 10:45 pm is asleep in observation no issues or concerns to report during shift everything is fine."

"3rd shift: [Resident 3] [sic] at 12:02 am via ambulance. Was very upset insulting staff and

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saying bad things about owner and peers. Monitor while going up the stairs, while changing clothes as [s/he] is under influence of alcohol. Complain about peer that [s/he] shares room with calling [him/her] names. Change clothes into pajamas and fell asleep at 12:30 am. Checking body and breathing temperature no issues. Sleeping all night woke up at 4 am to use restroom & wash hands & return to sleep. Woke up at 6:45 am turns radio on [sic] light on. Used restroom & wash hands, brush teeth & did all ADLs. Last check 6:53 am is making coffee and trying to go outside to smoke. No issue at shift."

-Resident 3's staffing case notes, dated 01/20/2026, documented the following:

"2nd shift: Upon arrival [Resident 3] is in bedroom laying down in bed. All meds given as schedule & offer water frequently. [Resident 3] says [s/he] always [sic] a water bottle in her purse. Use restroom as needed & wash hands. Refuse to let staff know when having a BM. Went to smoke to the back patio 3x every hr (hour) & talks to the neighbors & strangers. For dinner ate at 4:45 pm Eggs with Potatoes, drank orange juice with mango slices. Ate 100% of the meal. Clean up & wash hand. Return to bedroom laying down in bed & watch TV. At 6 pm [Resident 3] left the facility with [his/her] [adult child] and comeback at 7:15 pm. [Resident 3] was talking a lot [sic] about the house and how [s/he] hate to still living here, [his/her] conversation was slow and confuse, breath smell like alcohol. showing [sic] signs of intoxication for use of alcohol. Between [s/he] kept a conversation with a peer in the Kitchenette other employee went to [his/her] bedroom as something sound like had fallen, finding 3 bottles of Tequila Rose Strawberry Cream (shots size), two empty and one full down by [his/her] bed.

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	0016594	A. BUILDING: _____ B. WING _____	R-C 02/10/2026

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M 412	Continued From page 12 Notify owner, owner call after hour guardian office, and they said to remove bottle that is full. During the conversation [s/he] [sic] bad words and made comments about the another [sic], indicating they were dumb people and this cause the reaction of one peer was mad about [him/her]. Did not give meds because of condition [s/he] [sic], use restroom & wash hands, brush teeth & went to lay down. Insulting staff and peer [s/he] shares room with. Insulting owner over phone, going up and down the stairs, putting TV very loud peer cannot sleep. Lay down at 10:28 pm and fell asleep at 10:45 pm. No more issues." Resident 3's ISP, dated 11/03/2025, did not address Resident 3's substance use. On 02/05/2026, at 1:59 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 2's ISP did not include information regarding how staff were to manage Resident 2's behaviors. Licensee A confirmed Resident 3's ISP did not address Resident 3's substance use issues. Licensee A reported s/he was responsible for updating residents' ISPs. Licensee A did not provide Surveyor with reasoning for Resident 2's and Resident 3's ISPs not reflecting the above-mentioned information.	M 412		
{M 420}	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT 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:	{M 420}		

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{M 420}	Continued From page 13 Based on record review and interview, the provider did not ensure 1 of 4 residents (Resident 2) individual service plans (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 2's ISP did not include a signed statement of agreement with all parties involved. This is a repeat deficiency from Statement of Deficiency 8XOW11, dated 05/16/2025. Findings include: On 02/05/2026, Surveyor reviewed Resident 2's record and identified the following: - Resident 2 was admitted to the provider's home on 08/12/2020. - Resident 2 was his/her own person. - The consumer roster identified Resident 2 had a managed care organization (MCO) case management team. - Resident 2's ISP was dated 01/28/2026. Resident 2's ISP did not contain Resident 2's signature. - Resident 2's ISP was dated 01/28/2026. Resident 2's ISP did not contain MCO case management team signatures. On 02/05/2026, at approximately 12:14 PM, Surveyor interviewed Licensee A. Licensee A reported s/he forgot to obtain the above-mentioned signatures due to numerous situations being addressed doing Resident 2's care plan update meeting.	{M 420}		
{M 424}	88.06(3)(f) REVIEW OF ISP	{M 424}		

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{M 424}	Continued From page 14 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 ensure 1 of 1 resident (Resident 2) reviewed had his/her individual service plan (ISP) updated when there was a change in the resident's needs. Resident 2's ISP did not include Resident 2's fluid restriction. This is a repeat deficiency from Statement of Deficiency 8XOW11, dated 05/16/2025. Findings include: On 02/05/2026, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 08/12/2020.	{M 424}		

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{M 424}	Continued From page 15 -Resident 2's letter from his/her medical provider, dated 11/10/2025, documented the following: "Labs reviewed. [Resident 2] is on 2-liter (L) fluid restriction, change to 1.5 L fluid restriction." -Resident 2's after visit summary, dated 12/11/2025, documented the following: "Chief Complaint: Follow-up (Lab follow up). [Resident 2] presents for diabetic checkup and labs follow up. Encounter Diagnoses: Hyponatremia, type 2 diabetes mellitus without complication, without long-term current use of insulin, health care maintenance and weight loss. Plan: Hyponatremia - Likely dilutional, sodium improved, [Resident 2] on 1.5 L fluid restriction." -Resident 2's ISP, dated 01/28/2026, did not include information regarding Resident 2's fluid restriction. On 02/05/2026, at approximately 12:14 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 2's ISP did not include his/her fluid restriction. Licensee A reported s/he was responsible for updating residents' ISPs.	{M 424}		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT 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	M 610		

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M 610	Continued From page 16 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 4 residents (Resident 2) in the home. Resident 3 reported s/he observed behaviors that appeared to be emotionally and verbally abusive to Resident 2 and the provider did not report the incident. Findings include: On 02/05/2026, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 08/12/2020. -Resident 2 was his/her own person. -No observation notes regarding incident between Caregiver B and Resident 2. -No statements from Resident 2, Resident 3 or Caregiver B. -No investigation regarding the incident between Caregiver B and Resident 2.	M 610		

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M 610	Continued From page 17 On 02/05/2026, at approximately 8:20 AM, Surveyor interviewed Resident 2. Resident 2 stated that everything was going well in the home, and s/he had no concerns. On 02/05/2026, at approximately 9:05 AM, Surveyor interviewed Resident 3. Resident 3 reported the following: Resident 3 reported s/he observed behaviors from Caregiver B that appeared to be emotionally and verbally abusive to Resident 2. Resident 3 reported s/he has observed Caregiver B calling Resident 2 crazy, Caregiver B yelling and screaming at Resident 2, Caregiver B (approximately a week ago) locked Resident 2 in the back hallway and Resident 2 started banging on the door to get back in the home, Caregiver B taped (Duct tape) Resident 2's eye open, Caregiver B taped (Duct tape) Resident 2's month shut, Caregiver B taped (Duct tape) Resident 2's arm to chair in dining room while eating and Caregiver B taped (Duct tape) a bread/plastic bag around Resident 2's arm. Resident 3 reported that Caregiver B told him/her that s/he was a snitch. Resident 3 reported s/he informed Licensee A about the abuse about a week ago and Licensee A brushed it off and stated, "If you don't like living in the home then move." Resident 3 reported s/he has been reporting the abuse to his/her therapist. On 02/05/2026, Surveyor reviewed Department documentation and did not identify the provider submitted a report to the Department regarding the allegation of Caregiver B abusing Resident 2. On 02/06/2026, at approximately 2:23 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was made aware of the abuse	M 610		

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M 610	Continued From page 18	M 610		

allegation by Resident 3 on an unknown date. Licensee A confirmed Resident 2's record did not contain any observation notes, statements from Resident 2, Resident 3, and Caregiver B, and investigation documentation. Licensee A stated s/he would email Surveyor a Statement regarding his/her internal investigation regarding the allegation of caregiver misconduct by 5:00 PM.

On 02/06/2026, at 4:58 PM, Surveyor received an email from Licensee A. The email contained the following document: "Company Statement: Regarding the claim made by [Resident 3], an internal investigation occurred upon becoming aware of [his/her] comment. Originally, it was portrayed as if there had been an event of abuse. This possibility was disturbing so interviews were conducted to establish some context on the day rumored. Included in the process were the staff member on shift that day, [Caregiver B], the presumed victim [Resident 2], and the witness [Resident 3]. According to [Resident 3] there was an occurrence on an unpronounced day of which an altercation had occurred between [Caregiver B] and another resident [Resident 2] that consisted of yelling. After taking into consideration statements from the parties mentioned, it can be inferred that the claim lacked enough validity to consider [sic] true. Furthermore, upon asking [Resident 2] if [s/he] had been abused in any manner, physically, emotionally, or mentally; a denial was communicated. To rule out intimidation, a physical examination of [Resident 2's] body was considered and there were no signs of any abnormalities that would take precedence. Concluding that this may have been a case of misperception."

On 02/06/2026, at 5:33 PM, Surveyor interviewed

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M 610	Continued From page 19 Licensee A. Licensee A reported the following: "I only received statements verbally and I should have addressed it on the statement that I wrote specifically stating that. I did not submit a misconduct incident report to the Department."	M 610		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete caregiver background check (CBC) was completed every 4 years for 1 of 1 caregiver (Caregiver B) reviewed. Caregiver B's 4-year background check was due in May of 2025 and was not completed. At a minimum, a complete caregiver background check completed for a caregiver consists of the following three documents: - A completed DHS form F-82064, Background Information Disclosure (BID). - A response from the Department of Justice	Z 022		

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Z 022	Continued From page 20 (DOJ), either - A "no record found" response or - A criminal record transcript. - A Governmental Findings Report (previously "IBIS letter") from Department of Health Services (DHS) that reports the person's status, including administrative finding or licensing restrictions. Findings include: The provider is licensed to care for up to 4 residents within the following client groups: irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, advanced aged, developmentally disturbed, traumatic brain injury and physically disabled. On 02/05/2026, Surveyor reviewed Caregiver B's record and identified the following: -Caregiver B was hired on 05/05/2021. -Caregiver B's background check at hire was completed on 05/06/2021. -Caregiver B's record did not contain the BID, DOJ or Governmental Findings Report, of the four-year background check due May of 2025. On 02/05/2026, at approximately 1:59 PM, Surveyor interviewed Licensee A. Licensee A confirmed Caregiver B's record did not contain the BID, DOJ or Governmental Findings Report, of the four-year background check. Licensee A reported s/he is responsible for completing background checks. Licensee A reported s/he did not realize Caregiver B's four-year background check was due in May 2025.	Z 022		