| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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<br><br>On 01/27/2026 with information gathered through 01/28/2026, Surveyors conducted a verification visit and standard survey at Silence No More Home LLC, an Adult Family Home (AFH) in West Bend, WI.<br><br>Eleven deficiencies identified. Seven of 11 are repeat deficiencies from Statement of Deficiency (SOD) 0YCW11, dated 08/11/2025.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 3 | {M 000} | | |
| {M 114} | 88.03(3)(b) CRIMINAL RECORDS CHECK<br><br>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 | {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 |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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<br>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, Stats., or place conditions on the license.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 2 employees (Caregiver B and Manager D) reviewed had a completed background check at the time of hire.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 0YCW11, dated 08/11/2025.<br><br>Findings include:<br><br>According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete Caregiver Background Check, at minimum, consists of:<br><br>1) A completed DHS form F-82064, Background Information Disclosure (BID).<br>2) A response from the Department of Justice (DOJ).<br>3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also | {M 114} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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<br>referred to as the Goverment Finding Report.<br><br>On 01/27/2026 at approximately 9:20 AM, Surveyors requested complete background check information for Caregiver B and Manager D, from Manager D. Manager D provided Surveyors with employee file for Caregiver B. Manager D stated s/he did not have his/her employee file as s/he had started on 12/01/2025. Manager D showed Surveyors his/her DOJ and Goverment Findings report ran 10/02/2025, on his/her phone. Manager D confirmed s/he had given verbal permission to Administrator A to run his/her background, but s/he did not complete the BID.<br><br>-Caregiver B: Date of Hire - 05/01/2025<br>-BID form dated 05/05/2025 - completed<br>-No DOJ report<br>-No Government Finding report<br><br>-Manager D: Date of Hire - 12/01/2025<br>-No BID form<br><br>On 01/27/2026 at approximately 10:30 AM, Surveyors interviewed Manager D. Manager D stated s/he was working on updating the files for compliance.<br><br>On 01/28/2026 at 12:07 PM, Administrator A stated, "I fully understand the importance of maintaining compliance at all times and am committed to making the necessary improvements to ensure the safety, cleanliness, and well-being of our residents."<br><br>The provider did not ensure 2 of 2 employees (Caregiver B and Manager D) reviewed had a completed background check at the time of hire. | {M 114} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 216 | Continued From page 3 | M 216 | | |
| M 216 | 88.04(2)(a) RESPONSIBILITIES<br><br>The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interviews, the provider did not ensure the home and its operation complied with this chapter and all other laws governing the home and its operations potentially affecting 3 of 3 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations. At the time of this verification visit, the provider had 7 repeat violations. The provider did not follow Special Orders which resulted from previous Statement of Deficiency (SOD) 0YCW11, dated 08/11/2025.<br><br>Findings include:<br><br>On 09/24/2025, SOD 0YW11 and a Special Orders Letter were issued to Licensee A via email with the following:<br>Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Silence No More Home LLC:<br><br>1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., effective immediately, the licensee shall ensure all current and prospective service providers will have the necessary skills and training to fulfill job duties. Assigned tasks will be | M 216 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 216 | Continued From page 4<br>limited to the documented qualifications and demonstrated abilities of the service provider. Regardless of date of hire, each service provider will be fully trained before assuming the responsibilities of providing direct care without the supervision of a trained service provider.<br><br>WITHIN 45 DAYS of receipt of this notice, the licensee shall review the training records for each service provider and ensure the following:- Each service provider employed at least 6 months will have completed all initial training as required by Wis. Admin. Code § DHS 88.04(5)(a); and<br><br>- Each service provider who may be exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions prior to assuming duties that may expose the service provider to such material, and annually. Training will be provided by qualified instructors.<br><br>Training records will include the date/duration of training, an outline of course content and documentation of successful completion of the training requirements.<br><br>Additionally, WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for each current resident with a copy of Statement of Deficiency 0YCW11 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #1. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the | M 216 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 216 | Continued From page 5 | M 216 | | |

legal representative and case manager. Required evidence will be made available to the department representatives upon request.

On 01/27/2026, Surveyors conducted a verification visit and standard survey at Silence No More Home LLC. As a result of the survey, the provider was issued eleven deficiencies. Seven of the 11 were repeat deficiencies. The following deficiencies were identified:

N0114 DHS 88.03(3)(b) Criminal Records Check (repeat)
N0216 DHS 88.04(2)(a) Responsibilities
N0232 DHS 88.04(2)(g)1 Health Screening for Staff (repeat)
N0244 DHS 88.04(5)(a) Training-15 Hours Within 6 months (repeat)
N0334 DHS 88.05(4)(b)1 Fire Safety-Smoke Detectors
N0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing and Maintenance
N0344 DHS 88.05(4)(d)2.a Fire Safety Evacuation Plan Review (repeat)
N0380 DHS 88.06(2)(a) Admission-Health Exam (repeat)
N0384 DHS 88.06(2)(b) Service Agreement Except Respite (repeat)
N0458 DHS 88.07(3)(a) Prescription Medications
N0464 DHS 88.07(3)(d) Medication Written Order (repeat)

On 01/27/2026 at approximately 10:30 AM, Surveyors reviewed SOD 0YCW11 and Special Orders Letter with Manager D. Surveyors requested the training information for staff and the evidence of sending SOD 0YCW11 to all resident's legal guardians and case managers. Manager D stated s/he did not have that information since s/he had just started a few

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 216 | Continued From page 6<br>months ago in the role of the Manager of the house. Manager D stated s/he would have to reach out to Licensee A and see if s/he had the information regarding SOD 0YCW11 and Special Orders Letter. Surveyors gave Manager D and Licensee A until 8:00 AM on 01/28/2026 to send the additional information. Surveyors did not receive any additional information regarding SOD 0YCW11 and Special Orders Letter. | M 216 | | |
| {M 232} | 88.04(2)(g)1 HEALTH SCREENING FOR STAFF<br><br>The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed were screened for clinically apparent communicable disease, including tuberculosis (TB), within 90 days before the start of employment and that documentation of the test was available to the department.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 0YCW11, dated 08/11/2025. | {M 232} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 232} | Continued From page 7<br><br>Findings include:<br><br>On 01/27/2026 at approximately 9:20 AM, Surveyors requested the records for Administrator A, Caregiver B and Manager D from Manager D.<br><br>Administrator A's record did not have a date of hire, but Administrator A has worked at the facility since licensed on 07/29/2024. Administrator A had a completed communicable disease form signed by Administrator A. The form was not dated and was not signed by a registered nurse (RN). Administrator A's record did not have documentation a TB test.<br><br>Caregiver B was hired on 05/01/2025. Caregiver B's record had TB test results dated 05/09/2025. Caregiver B had a completed communicable disease form signed by Caregiver B. The form was not dated and was not signed by a RN.<br><br>Manager D was hired on 12/1/2025. Manager D did not have a record and did not have evidence s/he was tested for TB and did not have a screening for clinically apparent communicable disease.<br><br>The provider did not have documentation of a communicable disease screen, including TB test for Administrator A and Manager D, and communicable disease screen for Caregiver B. | {M 232} | | |
| {M 244} | 88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS<br><br>The licensee and each service provider shall complete 15 hours of training approved by the licensing agency | {M 244} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 244} | Continued From page 8<br>related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure that 2 of 2 employees reviewed received training in the resident rights with his/her initial training.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 0YCW11, dated 08/11/2025.<br><br>Findings include:<br><br>The provider is licensed to provide services for up to 4 residents who may have a developmental disability, physical disability, terminal illness, traumatic brain injury, Alzheimer's/dementia, emotionally disturbed/mental illness, correctional clients, pregnant women/counseling, alcohol/drug dependent and/or be advanced aged.<br><br>On 01/27/2026, Surveyors requested Administrator A and Caregiver B's employee record from House Manager D.<br><br>Administrator A's record did not have a date of hire, but Administrator A confirmed s/he had worked at the facility since being licensed 07/29/2024. Administrator A's record reflected CBRF training for first aid and choking, medication administration, standard precautions and fire safety. Administrator A did not have | {M 244} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 244} | Continued From page 9<br>resident rights training and training related to health, safety and welfare of the residents.<br><br>Caregiver B was hired on 05/01/2025. Caregiver B's record reflected CBRF training for first aid and choking, medication administration, standard precautions and fire safety. Caregiver B did not have resident rights training and training related to health, safety and welfare of the residents.<br><br>On 01/27/2026 at approximately 10:30 AM, Surveyors interviewed House Manager D. House Manager D stated s/he would connect with Administrator A and let him/her know and if s/he has the information s/he will send the information to Surveyors by the end of the day.<br><br>On 01/28/2026 at 12:07 PM, Administrator A sent Surveyors information but there was no additional information regarding resident rights training and training related to health, safety and welfare of the residents for Administrator A and Caregiver B. Administrator A stated s/he fully understands the importance of maintaining compliance at all times and am committed to making the necessary improvements to ensure the safety, cleanliness, and well-being of the residents.<br><br>The provider did not ensure that 2 of 2 employees reviewed received training in resident rights and training related to health, safety and welfare of the residents with his/her 15 hours of initial training within 6 months after starting. | {M 244} | | |
| M 334 | 88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS<br><br>Every adult family home shall be equipped with one or more single | M 334 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 334 | Continued From page 10 | M 334 | | |

station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure there was a smoke detector in 1 of 3 resident's room. There was no smoke detectors in Resident 4's bedroom.

Findings include:

On 01/27/2026, at 10:00 AM, Surveyors toured the home and observed the following:

-Resident 4's bedroom did not contain a smoke detector.

On 01/27/2025 at 10:00 AM, Surveyors interviewed Resident 4. Resident 4 stated s/he had never had a smoke detector in his/her room since s/he has lived there. Resident 4 stated s/he has lived there for a little over a month.

On 01/28/2025, at 2:53 PM, Surveyors interviewed Administrator A. Administrator A stated s/he completely understood about the smoke detector. Administrator A stated when

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 334 | Continued From page 11<br>they were changing the batteries, they completely forgot to put it back up.<br><br>CROSS REFERENCE<br>N0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing and Maintenance | M 334 | | |
| M 336 | 88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE<br><br>The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure each required smoke detector was tested monthly to make sure that the smoke detector was operating for 1 of 1 calendar year reviewed (2025).<br><br>Findings include:<br><br>On 01/27/2026 at approximately 9:45 AM, Surveyors requested documentation of the home's smoke detector tests from House Manager D. House Manager D provided Surveyors with a binder where smoke detector tests were documented. Surveyor did not see any smoke detector tests documentation for September, October, November and December | M 336 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 336 | Continued From page 12<br>of 2025.<br><br>On 01/27/2026 at approximately 10:00 AM, Surveyors interviewed House Manager D. House Manager D stated s/he would be honest and it looks like the smoke detectors have not been checked for awhile. House Manager D acknowledged the smoke detectors were not completed in September, October, November and December of 2025. | M 336 | | |
| {M 344} | 88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW<br><br>The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed were evaluated within 3 days of admission for evacuation time, using the Department's form.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 0YCW11, dated 08/11/2025.<br><br>Findings include:<br><br>On 01/27/2026, Surveyors requested Resident 4's resident records from Manager D. | {M 344} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 344} | Continued From page 13<br><br>Resident 4 was admitted to the facility on 12/25/2025. Resident 4 did not have an evacuation assessment. Manager D stated s/he was working with Resident 4's care team. Manager D acknowledged Resident 4 did not have a completed evacuation assessment.<br><br>On 01/28/2026 at 12:07 PM, Administrator A stated, "I fully understand the importance of maintaining compliance at all times and am committed to making the necessary improvements to ensure the safety, cleanliness, and well-being of our residents."<br><br>The provider did not ensure the fire safety evacuation plan was completed within 3 days of admission. | {M 344} | | |
| {M 380} | 88.06(2)(a) ADMISSION-HEALTH EXAM<br><br>Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 3 residents had been | {M 380} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 380} | Continued From page 14<br>screened for communicable diseases, including tuberculosis, within 90 days before and up to 7 days after admission.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 0YCW11, dated 08/11/2025.<br><br>Findings include:<br><br>On 01/27/2026, Surveyors requested Resident 1, Resident 4 and Resident 5's resident records from Manager D.<br><br>Resident 1 was admitted to the facility on 05/04/2025. Resident 1 did not have evidence s/he had been screened for communicable disease.<br><br>Resident 4 was admitted to the facility on 12/25/2025. Resident 4 did not have evidence s/he had been screened for communicable disease including tuberculosis.<br><br>Resident 5 was admitted to the facility on 10/16/2025. Resident 5 did not have evidence s/he had been screened for communicable disease including tuberculosis.<br><br>On 01/28/2026 at 12:07 PM, Administrator A stated "I fully understand the importance of maintaining compliance at all times and am committed to making the necessary improvements to ensure the safety, cleanliness, and well-being of our residents."<br><br>The provider did not ensure residents were screened for communicable diseases within 90 days before and up to 7 days after admission for 3 of 3 residents residing in the home for more than 7 days. | {M 380} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 384} | 88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE<br><br>An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any.<br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not have a service agreement for 1 of 3 residents reviewed (Resident 4).<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 0YCW11, dated 08/05/2025.<br><br>Findings include:<br><br>On 01/27/2026, Surveyors requested Resident 4's records from House Manger D.<br><br>Resident 4 was admitted to the facility on 12/25/2025, under respite. Resident 4 did not have an admission agreement completed when his/her respite exceeded 14 days. Resident 4 is his/her own person.<br><br>On 01/27/2026 at approximately 10:00 AM, Surveyors interviewed House Manager D. House Manager D stated Resident 4 came to the facility on 12/25/2025 and s/he was only going to be a | {M 384} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 384} | Continued From page 16<br>respite but s/he has stayed longer than the respite timeframe. House Manager D stated s/he did not have Resident 4 completed an admission agreement. | {M 384} | | |
| M 458 | 88.07(3)(a) PRESCRIPTION MEDICATIONS<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure medication was securely stored for 1 of 1 storage area. The home's medication closet was kept unlocked.<br><br>Findings include:<br><br>The provider's home is licensed to serve up to 4 individuals with client groups including developmentally disabled, traumatic brain injury, advanced age, physically disabled, pregnant woman/counseling, public funding, terminally ill, correctional clients, irreversible dementia/Alzheimer's, alcohol/drug dependent and emotionally disturbed/mental illness. | M 458 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 458 | Continued From page 17<br><br>On 01/27/2026 at approximately 10:00 AM, Surveyors toured the provider's home. Surveyors observed the provider's medication cabinet in the living room was not locked and there was another cabinet being built in the living room.<br><br>On 01/27/2026 at approximately 10:05 AM, Surveyors interviewed House Manager D. House Manager D stated the key got lost to the cabinet so they had to pry open the medication cabinet to get the residents medications to them. House Manager D stated the medications have been like this for the past 3 days and resident's do sometimes come out to the living room and watch television in there. House Manager D stated s/he was currently building a new medication cabinet and stated s/he would have them moved over by the end of the day and have the medications locked back up. | M 458 | | |
| {M 464} | 88.07(3)(d) MEDICATION- WRITTEN ORDER<br><br>Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the | {M 464} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 464} | Continued From page 18 | {M 464} | | |

provider did not ensure a written physician order to administer medication was obtained for 2 of 2 residents reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) 0YCW11, dated 08/11/2025.

Findings include:

On 01/27/2026 at approximately 9:20 AM, Surveyors requested Resident 1 and Resident 5's records from Manager D.

Resident 1 was admitted to the facility on 05/04/2025. Resident 1 did not have a written physician order stating who by name or position is permitted to administer the medication.

Resident 5 was admitted to the facility on 10/16/2025. Resident 5 did not have a written physician order stating who by name or position is permitted to administer the medication.

On 01/27/2026 at approximately 10:30 AM, Surveyors interviewed Manager D. Manager D confirmed they currently administer medications for Resident 1 and Resident 5. Manager D was unable to find documentation a written physician order to administer medication was obtained for 2 of 2 residents.

On 01/28/2026 at 12:07 PM, Administrator A stated "I fully understand the importance of maintaining compliance at all times and am committed to making the necessary improvements to ensure the safety, cleanliness, and well-being of our residents."

The provider did not ensure they had a written physician order stating who by name or position is

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020225 | A. BUILDING: _____ B. WING _____ | R-C 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILENCE NO MORE HOME LLC | 1666 TERRY DALE DRIVE W BEND, WI 53090 |

| (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 464} | Continued From page 19<br>permitted to administer the medication, prior to dispensing medication. | {M 464} | | |