STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	**1806 CREEK RD WEST 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 On 07/25/2025 with information gathered through 07/28/2025, Surveyor conducted two complaint investigations and a verification visit at Promise SIL LLC, an Adult Family Home (AFH) in West Bend, WI. Seven deficiencies identified. Three of seven are repeat deficiencies. One of two complaints substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
{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 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 1 of 1 resident reviewed was evaluated annually for evacuation time, using the department's form. Resident 4 had not been evaluated for evacuation time, using the department's form, since 05/30/2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 1USO11, dated 01/15/2025.	{M 346}		

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
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	**1806 CREEK RD WEST 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 346}	Continued From page 1 Findings include: On 07/25/2025 at approximately 9:30 AM, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's home on 05/21/2023. Resident 4's record did not include an evacuation assessment form since 05/30/2023. On 07/25/2025 at approximately 11:30 AM, Surveyor interviewed Licensee A. Licensee A stated s/he thought the evacuation only had to be completed upon admission and did not know it was an annual assessment. Licensee A stated s/he did not update since the last survey and would make sure moving forward all residents' evacuation assessments are completed upon admission and annually.	{M 346}		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	**1806 CREEK RD WEST 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 424	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not update the Individual Service Plan (ISP) every 6 months for 1 of 1 resident (Resident 4). Resident 4's ISP was due to be reviewed for an update by 07/15/2025 and was not reviewed or updated. Findings include: On 07/25/2025 at approximately 8:57 AM, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's home on 05/21/2023 and had a guardian. Resident 4's current ISP did not have a date on it but was signed by Resident 4's Power of Attorney (POA) on 01/15/2025. The 6 month review was due 07/15/2025. On 07/25/2025 at approximately 10:30 AM, Surveyor interviewed Licensee A. Licensee A stated s/he was aware that ISPs needed to be reviewed and updated every 6 months. Licensee A stated s/he was working on updating Resident 4's ISP since it had been past the 6 month review.	M 424		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	1806 CREEK RD WEST 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 3 This Rule is not met as evidenced by: 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. Findings include: On 07/25/2025 at approximately 8:17 AM, Surveyor toured the provider's home. Surveyor observed the provider's medication cabinet above sink was not locked. Surveyor observed a latch that would allow the closet to be locked by a paddle lock; however, there was not a lock engaged. On 07/25/2025 at approximately 10:45 AM, Surveyor interviewed Licensee A if the cabinet was usually kept unlocked. Licensee A stated, "No, staff know that it should be locked at all times." Licensee A opened the cabinet above sink and stated, "See, here is the lock," and locked up the cabinet. Licensee A stated s/he would follow up with Caregiver B since s/he was the caregiver during the shift and should have the cabinet locked at all times.	M 458		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care,	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	1806 CREEK RD WEST 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 556	Continued From page 4	M 556		

activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 3 residents were able to make decisions related to his/her activities. Resident 4 was not able to stay home when s/he was not feeling well and did not want to go to his/her day program.

Findings include:

On 07/25/2025, Surveyor reviewed Resident 4's record and identified the following:
-Incident report dated 03/19/2025 at 8:15 AM to 8:35 AM stated:
Describe where the incident took place:
Hallway/Living room/Van. "[Resident 4] came from smoking, stated [s/he] felt like [s/he] got [sic] to throw up, went to bathroom and didn't come out [sic] wanting to get in bed told [him/her] van about to pull up, [s/he] said [s/he] want to go back to bed, I redirected and talked with [him/her], [s/he] got verbally aggressive, calmed down and sat in chair. Van pulled up told [him/her] to put coat back on, [s/he] did and left out door. I told [him/her] have a good day and [s/he] got verbally aggressive. [Resident 4] got in van, verbally aggressive with driver. I stepped in redirected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	1806 CREEK RD WEST 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 556	Continued From page 5	M 556		

and talked to [him/her] and [s/he] calmed down and left for day program. Root cause of the incident: wanted to get in bed."

On 07/25/2025 at 8:38 AM, Surveyor reviewed police report regarding Resident 4's incident on 03/19/2025. The police report stated the following:
-"On 03/19/2025 at 1311 hours, [Officer] interviewed [Adult Day Program Caregiver E (ADPC E)] by phone. [ADPC E] was an employee at the [Adult Day Program]. [S/he] advised [Resident 4] arrived at the facility by bus. [ADPC E] advised after [Resident 4] arrived, [s/he] found [him/her] in the bathroom at the facility. [ADPC E] stated [s/he] observed [Resident 4] vomiting. [ADPC E] advised [Resident 4] told [him/her] in the bathroom [his/her] arm was hurt by the staff at [his/her] group home. [ADPC E] advised [s/he] was told by the bus driver that [Resident 4] was inconsolable about the incident on the ride to the [Adult Day Program]. [ADPC E] advised [s/he] helped [Resident 4] from the bathroom and called [his/her] case worker. [ADPC E] advised [Resident 4] told [him/her] [s/he] was forced out of bed, [his/her] cigarettes were taken, and [s/he] was forced to go to the day program even though [s/he] did not feel well."
-"On 03/19/2025 at 1405 hours, I interviewed [Resident 4] in the conference room regarding the incident. [Resident 4] advised [Caregiver B] aggressively pulled the blankets off of [him/her] in the morning and "yanked" [him/her] out of bed by both arms. [Resident 4] advised [s/he] walked out the dining room table where [Caregiver B] put food in front of [him/her]. [Resident 4] advised [s/he] ate the food not because [s/he] was hungry, but because [s/he] did not want to argue with [Caregiver B]. [Resident 4] stated [Caregiver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	**1806 CREEK RD WEST 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 556	Continued From page 6 B] would not let [him/her] have a cigarette and stated they were taken from [his/her] possession. [Resident 4] advised [Caregiver B] took them away from [him/her] for two weeks because [s/he] was not "compliant". [Resident 4] stated [s/he] felt as though the caregivers were mad because [s/he] was slow to move around. [Resident 4] advised [s/he] was yanked up from the chair [s/he] was sitting in and when [s/he] walked to the bathroom, [s/he] was pushed by [Caregiver B]. [Resident 4] advised [s/he] was pushed because [s/he] was not walking fast enough. On 07/25/2025, Surveyor interviewed Licensee A. Licensee A stated s/he was aware of the situation but s/he did not follow up with law enforcement and did not receive the police report. Surveyor reviewed police report with Licensee A. Licensee A stated s/he was unaware that Caregiver B told Resident 4 s/he could not stay home and that if a resident wanted to stay home, they should have the choice to because they are staffed 24/7. Licensee A stated s/he would follow up with Caregiver B and receive the entire police report for him/her to review in full. CROSS REFERENCE: N0610 DHS 88.11(1) Reporting Of Abuse and Neglect	M 556		
{M 570}	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from	{M 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	**1806 CREEK RD WEST 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 570}	Continued From page 7 environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were safeguarded from environmental hazards. The home's water temperature exceeded 120 degrees F. This is a repeat deficiency. See Statement of Deficiency (SOD) 1USO11, dated 01/15/2025. Findings include: On 07/25/2025 at approximately 9:22 AM, Surveyor tested the water temperature of the provider's bathroom located on the main floor. Surveyor's thermometer read a temperature peaking at 129.5 degrees F. Surveyor tested the water temperature of the kitchen sink. Surveyor's thermometer read a temperature of 130.6 degrees F. Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent	{M 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	1806 CREEK RD WEST 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 570}	Continued From page 8 disability. (DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017). On 07/25/2025 at approximately 9:30 AM, Surveyor interviewed Licensee A. Licensee A stated, "Yeah, we keep having problems with the water being too hot and we keep having to call the landlord about it. I will call [him/her] again about it."	{M 570}		
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 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 3 residents	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	1806 CREEK RD WEST 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 610	Continued From page 9	M 610		

in the home.

Findings include:

On 05/06/2025, the Department received a complaint alleging caregiver abuse and mistreatment of residents.

On 07/25/2025, at 08:30 AM, Surveyor reviewed Resident 4's record and identified the following:
-No observation notes regarding incident between Caregiver B and Resident 4.
-No investigation regarding the incident between Caregiver B and Resident 4.
-Incident report dated 03/19/2025 at 815 AM to 835 AM stated:
Describe where the incident took place: Hallway/Living room/Van. "[Resident 4] came from smoking stated [s/he] feel like [s/he] got [sic] to throw up, went to bathroom and didn't come out [sic] wanting to get in bed [sic] told [him/her] van about to pull up, [s/he] said [s/he] want to go back to bed, I redirected and talked with [him/her], [s/he] got verbally aggressive, calmed down and sat in chair. Van pulled up told [him/her] to put coat back on, [s/he] did and left out door. I told [him/her] have a good day and [s/he] got verbally aggressive. [Resident 4] got in van, verbally aggressive with driver. I stepped in redirected and talked to [him/her] and [s/he] calmed down and left for day program. Root cause of the incident: wanted to get in bed."

On 07/25/2025 at 8:38 AM, Surveyor reviewed police report regarding Resident 4's incident on 03/19/2025. The police report stated the following:
-"On 03/19/2025 at 1311 hours, [Officer] interviewed [Adult Day Program Caregiver E (ADPC E)] by phone. [ADPC E] was an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	1806 CREEK RD WEST 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 610	Continued From page 10	M 610		

employee at the [Adult Day Program]. [S/he] advised [Resident 4] arrived at the facility by bus. [ADPC E] advised after [Resident 4] arrived, [s/he] found [him/her] in the bathroom at the facility. [ADPC E] stated [s/he] observed [Resident 4] vomiting. [ADPC E] advised [Resident 4] told [him/her] in the bathroom [his/her] arm was hurt by the staff at [his/her] group home. [ADPC E] advised [s/he] was told by the bus driver that [Resident 4] was inconsolable about the incident on the ride to the [Adult Day Program]. [ADPC E] advised [s/he] helped [Resident 4] from the bathroom and called [his/her] case worker. [ADPC E] advised [Resident 4] told [him/her] [s/he] was forced out of bed, [his/her] cigarettes were taken, and [s/he] was forced to go to the day program even though [s/he] did not feel well."

-"On 03/19/2025 at 1405 hours, [Officer] interviewed [Resident 4] in the conference room regarding the incident. [Resident 4] advised [Caregiver B] aggressively pulled the blankets off of [him/her] in the morning and "yanked" [him/her] out of bed by both arms. [Resident 4] advised [s/he] walked out the dining room table where [Caregiver B] put food in front of [him/her]. [Resident 4] advised [s/he] ate the food not because [s/he] was hungry, but because [s/he] did not want to argue with [Caregiver B]. [Resident 4] stated [Caregiver B] would not let [him/her] have a cigarette and stated they were taken from [his/her] possession. [Resident 4] advised [Caregiver B] took them away from [him/her] for two weeks because [s/he] was not "compliant". [Resident 4] stated [s/he] felt as though the caregivers were mad because [s/he] was slow to move around. [Resident 4] advised [s/he] was yanked up from the chair [s/he] was sitting in and when [s/he] walked to the bathroom, [s/he] was pushed by [Caregiver B]. [Resident 4]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	1806 CREEK RD WEST 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 610	Continued From page 11 advised [s/he] was pushed because [s/he] was not walking fast enough. On 07/25/2025 at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A stated s/he was made aware of a situation with Caregiver B and Resident 4 when law enforcement showed up to the facility on 03/19/2025 to investigate the abuse allegation. Licensee A stated s/he did not get a copy of the police report after the case was closed. Surveyor asked Licensee A if s/he completed his/her own investigation involving his/her staff and residents. Licensee A stated s/he did not complete his/her own investigation. Licensee A stated s/he was unaware s/he needed to report this to the Department.	M 610		
{Z 010}	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint.	{Z 010}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	1806 CREEK RD WEST 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
{Z 010}	Continued From page 12 If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure every reasonable effort to contact the clerk of courts to determine the final disposition of a charge for a serious crime was made for 1 of 1 caregiver reviewed that had a charge of a serious crime. The provider did not make an effort to determine the final disposition of Caregiver C's charge of 940.01(1)(a) 1st Degree Intentional Homicide. This is a repeat deficiency. See Statement of Deficiency (SOD) 1USO11, dated 01/15/2025. Findings include: Chapter DHS 50.065(1)(e)1. defines "Serious Crime" as violation of s. 940.19 (3), 1999 stats., a violation of s. 940.01, 940.02, 940.03, 940.05, 940.12, 940.19 (2), (4), (5) or (6), 940.198 (2), 940.22 (2) or (3), 940.225 (1), (2) or (3), 940.285 (2), 940.29, 940.295, 948.02 (1), 948.025 or	{Z 010}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019750	A. BUILDING: _____ B. WING _____	R-C 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE SIL LLC	**1806 CREEK RD WEST 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
{Z 010}	Continued From page 13 948.03 (2) (a) or (5) (a) 1., 2., or 3., or a violation of the law of any other state or United States jurisdiction that would be a violation of s. 940.19 (3), 1999 stats., or a violation of s. 940.01, 940.02, 940.03, 940.05, 940.12, 940.19 (2), (4), (5) or (6), 940.198 (2), 940.22 (2) or (3), 940.225 (1), (2) or (3), 940.285 (2), 940.29, 940.295, 948.02 (1), 948.025 or 948.03 (2) (a) or (5) (a) 1., 2., or 3. if committed in this state. On 07/25/2025 at approximately 10:30 AM, Surveyor reviewed Caregiver C's record and identified the following: Caregiver C's Background Information Disclosure (BID) was dated 11/11/2024, Department of Justice (DOJ) dated 1/14/2025 and Integrated Background Information System (IBIS) dated 1/14/2025 The DOJ included a charge, dated 04/17/2015, of 940.01(1)(a) 1st Degree Intentional Homicide. The DOJ did not list the disposition. On 07/25/2025 at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A stated s/he was aware of the charge and when Surveyor was there for the last survey, s/he was made aware s/he was supposed to have the final disposition of the charge. Licensee A stated s/he had received a letter from Caregiver C's parole officer but did not receive the final disposition of the charge from the clerk of courts. Licensee A stated s/he thought the letter from the parole officer would suffice but s/he would get the additional information from the clerk of courts as soon as possible.	{Z 010}		