STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 01/26/2026 to 01/27/2026, Surveyor conducted a standard survey at Exceptional Living AFH Site 4. Four deficiencies were identified. Census: 4	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 2 of 2 residents reviewed were evaluated annually for evacuation time, using the department's form. Resident 1 and Resident 2 had not had an evacuation assessment, using the department's form, completed in 2025. Findings include: On 01/26/2026, Surveyor reviewed resident records and identified the following: Resident 1 was admitted to the facility on 01/05/2024. Resident 1's record did not contain an evacuation assessment for 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
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 Resident 2 was admitted to the facility on 06/20/2024. Resident 2's record did not contain an evacuation assessment for 2025. On 01/26/2026 at 1:00 PM, Surveyor interviewed Licensee A regarding the above concerns. Licensee A acknowledged s/he did not complete annual evacuation assessments for Resident 1 and Resident 2 in 2025. Licensee A stated s/he thought evacuation assessments were changed to every 2 years. Licensee A stated s/he would ensure all resident evacuation assessments were completed annually going forward.	M 346		
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: Based on record review and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and 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 1's and Resident 2's ISPs did not include a signed statement of agreement with all parties involved. Findings include:	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 420	Continued From page 2 On 01/26/2026, Surveyor reviewed residents' records and identified the following: -Resident 1 was admitted to the provider on 01/05/2024. Resident 1's record indicated s/he had a legal guardian. Resident 1's ISP dated 01/05/2026, was not signed by his/her guardian. -Resident 2 was admitted to the provider on 06/20/2024 with a diagnosis of dementia. Resident 2's record indicated s/he had an activated healthcare power of attorney. Resident 2's ISP dated 12/11/2025, was not signed by his/her legal representative. On 01/26/2026 at 1:00 PM, Surveyor interviewed Licensee A regarding the above concerns. Licensee A acknowledged residents' ISPs did not include a signed statement of agreement with all parties. Licensee A stated Resident 1's guardian only attended care conferences virtually so s/he would have to work his/her care team to acquire the guardian's signature. Licensee A did not provide a reason to why Resident 2's ISP was not signed by his/her legal representative.	M 420		
M 514	88.09(2)(a) SERVICE PROVIDER RECORD Service provider record. The licensee shall maintain and keep up to date a separate personnel record for each service provider. The licensee shall ensure that all service provider records are adequately safeguarded against destruction, loss or unauthorized use. A service provider	M 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 514	Continued From page 3 record shall include all of the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all service provider records were adequately safeguarded against destruction or loss. The provider did not maintain record of complete background checks in 3 of 3 employees. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), a complete Caregiver Background Check, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A Governmental Findings Report from DHS that reports the person's status, including administrative finding or licensing restrictions (IBIS). On 01/26/2026 at 1:00 PM, Surveyor requested complete background checks from Licensee A including the BID, DOJ and IBIS, for Caregiver B, Caregiver C and Caregiver D. Licensee A reported employee files were at his/her main office, so s/he asked the Surveyor if employee files could be sent via email. Surveyor stated records needed to be sent by the end of the day. Licensee A verbally agreed. On 01/26/2026 at 7:35 PM, Licensee A sent the following email: "Good evening, Lots of emails. I reran everyone today, as some of the files got wet from the flood.	M 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 514	Continued From page 4 [Resident 2's] medication orders were in [his/her] chart, I was just distracted by them wanting my attention. If you need anything else please let me know." On 01/27/2026, Surveyor reviewed employee records and identified the following: -Caregiver B was hired on 11/15/2025. Caregiver B's record included a DOJ and IBIS report, dated 01/26/2026 (day of survey). License A provided another DOJ/IBIS report for Caregiver B but the date was not legible and the report appeared water damaged. -Caregiver C was hired 06/04/2019. Caregiver C's record included a DOJ and IBIS report dated 01/26/2026 (day of survey). The record did not include a BID. -Caregiver D was hired 07/29/2025. Caregiver D's record included a DOJ and IBIS report dated 01/26/2026 (day of survey). The record did not include a BID. On 01/27/2026 at 2:54 PM, Surveyor conducted an exit conference and shared findings with Licensee A. Licensee A acknowledged s/he did not safeguard employee files from destruction or loss. Licensee A reported employee files kept at the main office were damaged in the floods that occurred in August 2025. Licensee A reported when s/he discovered the filing cabinet had been water damaged s/he had to peel paper apart to try to salvage the records. Licensee A reported s/he ran all staff again on the day of survey (01/26/2026).	M 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 023	Continued From page 5	Z 023		
Z 023	50.065(4m) (b) intro CAREGIVER HIRING AND CONTRACTING PROCESS Notwithstanding s.111.335, and except as provided in sub. (5), an entity may not hire or contract with a caregiver or permit to reside at the entity a nonclient resident if the entity knows or should have known any of the following: 1. That the person was convicted of a serious crime. 3. That a unit of government or a state agency, as defined in s. 16.61 (2) (d), has made a finding that the person has abused or neglected any client or misappropriated the property of any client. 4. That a determination has been made under s. 48.981 (3) (c) 4. that the person has abused or neglected a child. 5. That, in the case of a position for which the person must be credentialed by the Department of Safety and Professional Services, the person's credential is not current, or is limited so as to restrict the person from providing adequate care to the client. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure 1 of 1 employee with a finding of neglect by a government agency was not allowed	Z 023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 023	Continued From page 6	Z 023		

to work with residents. Licensee A conducted a background check on Caregiver B which showed that Caregiver B was on the misconduct registry, but Caregiver B was allowed to work until the day of survey. This presented a potential risk to the residents of the facility.

Findings include:

The provider is able to serve up to 4 residents within the client groups of traumatic brain injury, irreversible dementia/Alzheimer's, correctional clients, emotionally disturbed/mental illness, developmentally disabled, advanced age, and terminally ill.

On 01/26/2026, Surveyor observed Caregiver B working in the facility. Surveyor observed Caregiver B prepare lunch and assist residents with cares. Licensee A reported employee files were at his/her main office, so s/he asked the Surveyor if employee files could be sent via email. Surveyor stated records needed to be sent by the end of the day. Licensee A verbally agreed.

On 01/27/2026, Surveyor reviewed Caregiver B's record. Caregiver B was hired on 11/15/2025.

Caregiver B's background information disclosure (BID) was dated 11/14/2025. Surveyor reviewed the following response:
Question 4, "Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? If Yes, explain, including when and where it happened."
The response area was marked "No."

Caregiver B's Integrated Background Information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 023	Continued From page 7	Z 023		

System (IBIS), dated (illegible due to water damage), noted Caregiver B had a finding of neglect on 08/13/2020. Surveyor verified the findings as noted on the Caregiver Misconduct Registry. The findings documented that Caregiver B was not eligible to work as a caregiver in a DHS regulated facility in Wisconsin. Further review of the IBIS indicates Caregiver B had not completed a rehabilitation review process allowing him/her to work in a DHS regulated facility.

Surveyor reviewed staff schedules dated 12/01/2025 to 01/27/2026. Caregiver B was scheduled to work on the following dates: 12/07/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/15/2025, 12/16/2025, 12/17/2025, 12/18/2025, 12/20/2025, 12/23/2025, 12/24/2025, 12/25/2025, 12/26/2025, 12/29/2025, 12/30/2025, 12/31/2025, 01/03/2026, 01/06/2026, 01/13/2026, 01/14/2026, 01/15/2026, 01/17/2026, 01/18/2026, 01/21/2026, 01/22/2026, 01/23/2026, 01/26/2026, and 01/27/2026.

A review of the summary of the substantiated findings of abuse documented:
"Caregiver Name: [Caregiver B]
DQA report #71936
Incident:
-Date Occurred: 02/29/2020
-Description: On or about February 29, 2020, at [previous provider], [Caregiver B] left the facility prior to relief staff arriving, leaving the clients unsupervised.
-Decision: Neglect
-Date Finding Placed On Registry: 08/13/2020."

On 01/27/2026 at 2:54 PM, Surveyor interviewed Licensee A and Caregiver B. Caregiver B reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019757	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL LIVING AFH SITE 4	W129N8465 REVERE DR MENOMONEE FALLS, WI 53051

(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 023	Continued From page 8 s/he was not aware s/he had been placed on the caregiver misconduct registry. Caregiver B reported s/he thought the relief staff was in the driveway at his/her previous employer before leaving the home. Caregiver B stated s/he had another job lined up, so s/he never went back to his/her previous employer after the incident. Licensee A reported s/he was responsible for reviewing caregiver background checks for staff. Licensee A reported s/he overlooked Caregiver B's original background check and did not see the findings of neglect until s/he reran Caregiver B's background check on 01/26/2026. Licensee A reported there had never been any concerns with Caregiver B while s/he was employed. Licensee A acknowledged s/he had not reviewed Caregiver B's background check closely and s/he would accept the violation.	Z 023		