STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014249	A. BUILDING: _____ B. WING _____	R-C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN PATH SENIOR LIVING CORP	10343 W DONNA DR MILWAUKEE, WI 53224

(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 09/18/2025, Surveyor completed a standard survey, verification visit and 2 complaint investigations at Golden Path Senior Living Corp. As a result, the previous deficiency was recited and 2 new deficiencies were identified, for a total of 3 deficiencies. Two complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 2	{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 services the licensee would provide to meet the needs for 2 of 2 residents (Resident 2 and Resident 3). Resident 2 exhibited behaviors and had a behavior support plan (BSP). Resident 2's Individual Service Plan (ISP) did not indicate Resident 2 had behaviors or direct staff to review Resident 2's BSP. Resident 3's ISP did not include information relating to Resident 3's lack of supervision while in the community but required 24-hour	{M 412}		

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
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{M 412}	Continued From page 1	{M 412}		

supervision in the home.

This is a repeat deficiency. See Statement of Deficiency (SOD) 2WCD11, dated 03/30/2022.

Findings include:

On 08/15/2025, the department received a complaint alleging concerns with resident behaviors.

On 08/26/2025, Surveyor reviewed resident records and identified the following:

Example 1:

Resident 2 was admitted on 03/26/2025 with diagnoses including autism, borderline personality disorder, attention-deficit hyperactivity disorder, explosive disorder intermittent and schizophrenia. Resident 2's ISP, dated 03/26/2025, under "behavioral intervention" indicated Resident 2 required redirection "sometimes when [s/he] do not [sic] gets [sic] [her/his] way." Resident 2's ISP did not indicate any specific behaviors and did not direct staff to review Resident 2's BSP.

Resident 2's BSP, dated 05/19/2025, indicated Resident 2 had the following behaviors:

- Physical aggression: hitting staff and residents, slamming doors, pounding on walls

- Verbal aggression: yelling

- Property Destruction: throwing objects, tearing items off walls, breaking windows, breaking furniture.

Staff should respond when behaviors occur by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{M 412}	Continued From page 2	{M 412}		

speaking in a calm, neutral tone, remind Resident 2 everything is ok, offer space and ensure the safety of everyone, offer paper so Resident 2 can write down her/his feelings, offer a phone call to family.

Resident 2's member centered care plan (MCP), dated 06/01/2025, indicated Resident 2 had been having behaviors for "almost a year now". Behaviors included breaking things and hitting others.

Surveyor reviewed the following incident reports:

04/07/2025 at 10:47 PM - Resident 2 had a snack in the kitchen, slammed down the chair. Caregiver attempted to redirect Resident 2 to her/his room. Resident 2 hit caregiver in the arm twice and then yelled for 2 hours. Caregiver gave Resident 2 an as needed (PRN) medication at 2:20 AM.

04/08/2025 at 5:30 PM - Resident 2 slapped another resident.

04/09/2025 at 7:35 PM - Resident 2 had an accident while waiting for the bathroom. Resident 2 started yelling and slapped caregiver on the back of the head. Resident 2 hit caregiver in the arm and continued to scream until s/he stopped and went to her/his room.

04/13/2025 at 7:30 PM - Resident 2 hit caregiver in the face, which broke her/his glasses and cut her/his lip.

04/20/2025 at 4:00 PM - Resident 2 slapped caregiver in the face, started yelling and throwing items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{M 412}	Continued From page 3 04/22/2025 at 12:00 PM - Resident 2 became upset, slapped caregiver, hit the television, and yelled for 10 minutes. 04/22/2025 at 7:05 PM - Resident 2 had a snack, then went to the fridge for more. Caregiver started to redirect Resident 2 when s/he became combative and started yelling. 04/22/2025 at 7:44 PM - Resident 2 threw a plaster statue of an angel at the wall. 04/23/2025 at 10:39 PM - Resident 2 threw a glass table. 04//28/2025 at 11:18 PM - Resident 2 started hitting the door, which caused the windows to break. 05/01/2025 at 11:30 AM - Resident 2 threw her/his radio and pushed the television over. 05/13/2025 at 7:50 AM - Resident 2 hit another resident in the back and broke her/his dresser. 05/22/2025 at 5:30 AM - Resident 2 was yelling, s/he pushed the television, rocking chair and recliner over. 05/24/2025 at 12:15 PM - Resident 2 hit caregiver and grabbed her/his arm with her/his nails, causing caregiver to bleed. 05/24/2025 at 7:50 PM - Resident 2 started yelling and ran towards the window with her/his arms out. Resident 2 hit the window and broke it. 05/31/2025 at 5:00 PM - Resident 2 had outbursts all day. At dinner, Resident 2 threw a plate at the wall, breaking the plate. Resident 2	{M 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{M 412}	Continued From page 4	{M 412}		

ran towards the television, caregiver stopped her/him and got scratched in the eye.

06/24/2025 at 10:00 PM - Resident 2 was yelling throughout the day. Resident 2 ran to the door and put her/his fist through the front window.

07/13/2025 at 7:45 AM - Resident 2 was yelling and ran out the door.

07/20/2025 at 10:11 AM - Resident 2 was yelling, picked up a kitchen chair and slammed it on the ground, breaking the chair. Resident 2 started to hit the wall in the living room and was hitting caregiver.

07/26/2025 at 7:15 PM - Resident 2 hit another resident on her/his arm.

07/28/2025 at 7:49 AM - Resident 2 started to open and slam her/his bedroom door and was yelling.

07/29/2025 at 7:50 PM - Resident 2 threw her/his radio at the wall. Resident 2 calmed down, then ran towards the window and broke it.

08/01/2025 at 11:15 AM - Resident 2 slapped another resident in the face.

08/02/2025 at 12:45 PM - Resident 2 slapped another resident in the face.

08/13/2025 at 7:30 PM - Resident 2 threw staff's cell phone, breaking it, then ran to another resident's bedroom, locked the door, and started to throw items.

08/16/2025 at 5:30 AM - Resident 2 hit staff in the mouth and scratched staff's face. Resident 2

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{M 412}	Continued From page 5	{M 412}		

threw a box fan down the hall; Resident 2 was on the couch yelling. Staff attempted to calm Resident 2 down by letting Resident 2 sit outside, when Resident 2 threw a chair in the lawn and attempted to run away. Resident 2 returned to the house and started hitting the van in the driveway. Resident 2 attempted to hit staff. Staff was able to get Resident 2 in the house and aggressions started again.

Summary: Resident 2's ISP did not reference Resident 2's behaviors, how staff were to respond to Resident 2's behaviors, any interventions the provider put in place for assist Resident 2 with her/his behaviors, or reference Resident 2's BSP to assist with Resident 2's behaviors.

Example 2:

Resident 3 was admitted on 05/30/2020 with diagnoses including autism and schizophrenia. Resident 3's ISP, dated 05/01/2025, indicated the following:

"Supervision
- Member requires twenty-four-hour supervision (cannot be left alone). Yes
- Member can spend 0 hours at a time unsupervised
- Member can come and go from the [adult family home] as they desire. Yes
Comments walk to the park only."

Summary: Resident 3's ISP did not indicate why Resident 3 required 24-hour supervision in the home and cannot spend time unsupervised. Resident 3's ISP did not indicate why Resident 3 did not require supervision when at the park.

On 09/18/2025, at 8:00 AM, Surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014249	A. BUILDING: _____ B. WING _____	R-C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 412}	Continued From page 6 Licensee A and Administrator E. Administrator E reported s/he was responsible for completing resident ISPs. Administrator E reported Resident 3 was able to go to the park to swing and s/he wore a tracker on her/his arm. Administrator E reported Resident 3 was unable to be in the home without staff because s/he would ask for items like a lighter. Administrator E reported Resident 2 had different interventions in place for behaviors, for example, s/he used plastic plates to ensure if s/he threw it, the plate would not break. Administrator E reported they were able to tell when Resident 2 was going to have a behavior because s/he would fidget with her/his hands and call out a specific word. When Surveyor inquired why all the information was not included in the ISPs, Licensee A acknowledged resident ISPs needed to include all information regarding residents.	{M 412}		
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	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 424	Continued From page 7 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 3's) individual service plan (ISP) was reviewed every 6 months by the licensee, the resident or resident's legal representative and managed care organization (MCO) care managers. Resident 3's ISP was not reviewed with her/his legal representative and MCO care managers. Findings include: On 08/26/2025, at 10:25 AM, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 05/30/2020 with diagnoses including autism and schizophrenia. Resident 3 had a guardian. Resident 3's ISP, dated 05/01/2025, was signed by Administrator E. Resident 3's ISP was not signed by Resident 3's guardian or Resident 3's MCO care managers. On 09/18/2025, at 8:00 AM, Surveyor interviewed Licensee A and Administrator E. Administrator E reported s/he conducts the ISP reviews every 6 months with staff. Administrator E reported s/he was unaware legal representatives and MCO care managers were required to sign resident ISPs.	M 424		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew,	M 556		

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	0014249	A. BUILDING: _____ B. WING _____	R-C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN PATH SENIOR LIVING CORP	10343 W DONNA DR MILWAUKEE, WI 53224

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M 556	Continued From page 8	M 556		

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 allow 1 of 1 resident (Resident 2) to return to the facility. Resident 2 was not allowed back at the facility after s/he was treated at a mental health center.

Findings include:

On 08/25/2025, the Department received a complaint alleging the provider would not allow a resident back to the facility.

On 08/26/2025, at 10:15 AM, Surveyor interviewed Caregiver F. Caregiver F reported Resident 2 was no longer residing at the facility.

On 08/26/2025, at 10:15 AM, Surveyor reviewed Resident 2's file. Resident 2 was admitted on 03/26/2025 with diagnoses including autism, borderline personality disorder, attention-deficit hyperactivity disorder, explosive disorder intermittent and schizophrenia. Resident 2's assessment, dated 03/26/2025, indicated Resident 2 required a continuous positive airway pressure (CPAP) machine. The remainder of the assessment was blank. The assessment was signed by Administrator E and Resident 2's guardian.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014249	A. BUILDING: _____ B. WING _____	R-C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN PATH SENIOR LIVING CORP	10343 W DONNA DR MILWAUKEE, WI 53224

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M 556	Continued From page 9 On 09/03/2025 at 11:27 AM, Licensee A emailed Surveyor Resident 2's assessment with filled out responses. The assessment, dated 03/26/2025, indicated Resident 2's behavior and/or mental status was alert, oriented, cooperative, combative which started in the summer of 2024 and wanders which Resident 2 left the house in October 2024. Special concerns noted, "none [sic] [s/he] was nice and polite." Resident 2's individual service plan (ISP), dated 03/26/2025, under "behavioral intervention" indicated Resident 2 required redirection "sometimes when [s/he] do not [sic] gets [sic] [her/his] way." Resident 2's ISP did not indicate any specific behaviors or did not direct staff to review Resident 2's behavior support plan (BSP). Resident 2's BSP, dated 05/19/2025, indicated Resident 2 had the following behaviors: - Physical aggression: hitting staff and residents, slamming doors, pounding on walls - Verbal aggression: yelling - Property Destruction: throwing objects, tearing items off walls, breaking windows, breaking furniture. Staff should respond when behaviors occur by speaking in a calm, neutral tone, remind Resident 2 everything is ok, offer space and ensure the safety of everyone, offer paper so Resident 2 can write down her/his feelings, offer a phone call to family. Resident 2's member centered care plan (MCP), dated 06/01/2025, indicated Resident 2 had been	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014249	A. BUILDING: _____ B. WING _____	R-C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 556	Continued From page 10 having behaviors for "almost a year now". Behaviors included breaking things and hitting others. Resident 2's record contained a 30-day notice of tenant termination letter, dated 07/15/2025, which stated the following: " ...It is with deep regret that we must provide [Resident 2] with a 30-day notice of tenant termination, effective August 15th. Our team has made every effort to support [Resident 2], and meet [her/his] needs, diligently working to redirect [her/his] behavior and create a nurturing environment. However, the continuous incidents of harm to others and damage to property have surpassed our capacity to manage effectively. As a small adult family home, we have exhausted our budget and attempts to accommodate [Resident 2], including scheduling additional staff, overtime, and hiring new employees specifically to address [her/his] unique challenges. Unfortunately, we have received numerous complaints from other residents expressing their concern and fear regarding [Resident 2's] behavior. Their safety and peace of mind are paramount, and several are actively seeking alternative placements due to the disturbances they have experienced. While there have been moments of kindness and cooperation from [Resident 2], it has been increasingly clear that [her/his] needs extend beyond what a group living environment can provide. [S/He] would benefit more from one-on-one care that can cater to [her/his] specific requirements .... I also have additional resources that may be better suited to accommodate [her/his] needs, and I would be more than willing to share contact information for other appropriate adult family homes ..."	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014249	A. BUILDING: _____ B. WING _____	R-C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 556	Continued From page 11 On 07/29/2025, at 12:32 PM, Licensee A emailed MCO Case Manager (CM) G. The email stated the following: " ...I am reaching out to discuss the possibility of putting together a proposal for [Resident 1]. As you know, we provided [her/him] with a 30-day notice to vacate our current AFH, be we have acquired a second location that we believe could serve [her/his] needs more effectively. Our intention for this new location is to focus on individuals with challenging complex behaviors and non-ambulatory members, making it an ideal environment for [Resident 2] to receive dedicated, one-on-one care. Currently, our existing AFH faces challenges in managing [Resident 2's] behaviors. Despite our best efforts, we have been unable to effectively redirect [her/him] or manage some incidents of physical aggression, particularly towards other residents ... The transition would allow us to offer [Resident 2] individualized attention and support. We can establish one-on-one rates tailored specifically for [her/his] care, allowing us to concentrate solely on [her/him] during [her/his] stay. On 07/29/2025, at 1:56 PM, MCO CM G emailed Licensee A. The email stated the following: " ...The issue right now is that we had a meeting recently on [Resident 2], where we discussed one on one staffing for [her/him] and it was determined by some people in the meeting that a 3:2 or 4:2 staffing pattern needed to be tried first ...I think based on what you have seen in [Resident 2's] behaviors that the proposal is fair but for right now ...we need to try the 3:2 or 4:2 staffing pattern ...We could look at one on one staff again if a 3:2 or 4:2 does not work, either at one of your homes or at a different AFH (adult family home) ..." An incident report dated 08/16/2025, indicated at	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 556	Continued From page 12 5:30 AM, Resident 2 was in the living room on the couch, got up and smiled at staff. Resident 2 then hit staff in the mouth and scratched staff's face. Resident 2 threw a box fan down the hall and attempted to open another resident's locked bedroom door. Later when the next shift came in, Resident 2 was on the couch yelling. Staff attempted to calm Resident 2 down by letting Resident 2 sit outside, when Resident 2 threw a chair in the lawn and attempted to run away. Resident 2 returned to the house and started hitting the van in the driveway. Resident 2 attempted to hit staff. Staff was able to get Resident 2 in the house and aggressions started again. The police and crisis team were called. The follow-up plan indicated to keep redirecting Resident 2, keep Resident 2 separate from the other residents, and contact police and crisis team when Resident 2 starts to assault others. On 09/17/2025, at 9:00 AM, Surveyor reviewed Resident 2's discharge summary from the hospital which indicated Resident 2 was admitted on 08/16/2025 due to not having a place to live. Resident 2 was discharged from Mental Health Emergency Center on 08/16/2025, after 8 hours of observation with no displays of aggression, and returned to the group home via ambulance. Once Resident 2 arrived at the group home, "they wrote a letter stating the patient has been discharged ...the discharge date was August 15, and [s/he] is past that date ...". Social Worker notes indicated numerous phone calls to the group home and Administrator E had not been returned. On 09/18/2025, at 8:00 AM, Surveyor interviewed Licensee A and Administrator E. Licensee A, and Administrator E confirmed Resident 2 was discharged on 08/16/2025. Administrator E	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014249	A. BUILDING: _____ B. WING _____	R-C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN PATH SENIOR LIVING CORP	10343 W DONNA DR MILWAUKEE, WI 53224

(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 13 reported Resident 2's 30 days was up on 08/15/2025 and during the time Resident 2 was experiencing a lot of aggressive behaviors. When Surveyor inquired about why Resident 2 was refused from entry when s/he returned to the home by ambulance, Administrator E reported it was because Resident 2 was getting worse. Licensee A reported s/he was unaware Resident 2 returned to the home by ambulance and was refused entry. When Surveyor inquired why Administrator E did not return the hospital social workers phone calls in regard to Resident 2, Administrator E did not offer an answer.	M 556		