STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019575	A. BUILDING: _____ B. WING _____	C 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GODS CARE	652 DAMASCUS TRL COTTAGE GROVE, WI 53527

(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 10/02/2026 with information gathered through 10/09/2026, Surveyor conducted 1 complaint investigation at Gods Care. Three deficiencies were identified. The complaint was substantiated. Census: 3	M 000		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 2 means of emergency exiting to the designated emergency spot identified in the emergency plan. The home had a front door, side door leading to fenced backyard, and garage with no utility door. The backyard fence's gait was camoflauged as locked with combination padlock and Caregiver C, who was working alone on 10/02/2026 did not know how to unlock the padlock. Findings include: The adult family home is licensed to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, advanced aged,	M 338		

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

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M 338	Continued From page 1	M 338		

developmentally disabled, traumatic brain injury, and terminally ill.

On 10/02/2026 at 11:50 AM, Surveyor arrived at God's Care. Caregiver B was working alone.

On 10/02/2026 at 12:17 PM, Surveyor observed the backyard and interviewed Caregiver B. The back yard was fenced in and the fence had 2 gaits. The gait closest to the house was blocked by shrubs (photo 1). The 2nd gait's latch had a combination style padlock on it and the padlock appeared locked (Photo 2). Caregiver B stated the padlock was on the gait latch so Resident 1 would not leave the yard. Caregiver B stated s/he did not know s/he would open the gait because s/he did not how to unlock the padlock. Caregiver C stated and did not know how long the padlock had been on the gait latch and they would exit through the front door in case of a fire.

10/02/2026 at 12:17 PM Surveyor toured the home with Caregiver B. The only exits from the home were the front door, door leading to backyard, and overhead electric garage door (no utility door in garage).

On 10/06/2026 at 12:09 PM, Surveyor interviewed Licensee A who stated s/he placed the combination padlock on the gait to confuse Resident 1 but the lock was not locked, it just appeared locked. Licensee A stated staff were trained on the combination lock and Caregiver B should have remembered s/he only needed to pull the latch down for the gait to open and the 3 number combination was written on the back of the lock.

On 10/06/2026 at 3:13 PM, Surveyor received Caregiver B's training on the lock via email from

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M 338	Continued From page 2 Licensee A. "Staff Acknowledgement Gate and Combination Lock Operation for Emergency Access and Evacuation ...I, the undersigned staff member, acknowledge that I have received, understood and am able to operate the gate and combination padlock located our facility as explained below. This knowledge is for emergency use only (emergency drills and real emergency evacuation). 1. How to Open the Gate and Padlock 1. Use the combination lock to open the padlock. 2. Pull the gate toward you (DO NOT push). 3. The gate will open because the padlock did not completely close the gate. It is just for camouflaging, not to lock it fully. In Case of Emergency (If the Gate Does Not Open) If the gate does not open properly during an emergency drill or real emergency evacuation, I acknowledge and know how to: Use the combination on the padlock to unlock it. I understand the combination is located on the padlock (see photo above). I have practiced or been trained on how to enter the combination correctly. I acknowledge that I understand and can: Operate the padlock with the combination Pull the gate toward me (not push) Use the combination to open the gate if needed during an emergency This knowledge is for emergency use only." There were 2 photos on the training document. The first depicted the padlock on the gate latch and the 2nd was a close-up of the front of the padlock. There was no photo depicting the combination located on the back of the padlock. 10/09/2026 at 2:06 AM, Surveyor received the homes "FIRE EMERGENCY & EVACUATION PLAN" dated 10/03/2026 from Licensee A " ...PRIMARY EXIT - FRONT ENTRANCE ... ALTERNATE EXIT - ATTACHED GARAGE DO NOT use the garage route if there is fire or smoke	M 338		

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M 338	Continued From page 3 in the garage, if the route is blocked, or if any part of the route appears unsafe. Do not rely on an automatic garage door as the only means of escape; staff must know the safe, available way to exit ...ALTERNATE EXIT - BACKYARD DOOR AND GATE ... Use this route only if the hallway, backyard door, backyard, and gate are safe and accessible. The gate is capable of being opened quickly from inside during an emergency, without searching for a key or combination (because the Padlock [sic] is for camouflage) we no longer have the padlock at the gate ... ASSEMBLY AREA AND ACCOUNTABILITY After exiting, move to a designated safe location away from the building, smoke, the driveway, falling debris, and fire department access. The assembly area must be outside the fenced backyard and away from the house ..." On 10/09/2026 at 8:06 AM, Surveyor emailed Licensee A stating " ...It appears the fire evacuation plan was updated on 10/03/2026. Please send me the version that was effective on 10/02/2026 ..." 10/09/2026 9:56 AM, Surveyor received an email from Licensee A with attached ""FIRE EMERGENCY & EVACUATION PLAN" dated 09/25/2026. " ...ALTERNATE EXIT - BACKYARD DOOR AND GATE ...Use this route only if the hallway, backyard door, backyard, and gate are safe and accessible. The gate is capable of being opened quickly from inside during an emergency, without searching for a key or combination (because the Padlock is for camouflage) ... ASSEMBLY AREA AND ACCOUNTABILITY After exiting, move to a designated safe location away from the building, smoke, the driveway, falling debris, and fire department access. The assembly area must be outside the fenced backyard and away from the house ..."	M 338		

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M 338	Continued From page 4 Cross Reference: M0436 DHS 88.07(2)(a) Services	M 338		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure services specified in the resident's individual service plan (ISP) were provided. Resident 1's ISP was not implemented when staff allowed him/her to go off the adult family home's property alone, putting Resident 1's safety in jeopardy. On 09/10/2026, the Department received a complaint regarding insufficient supervision of Resident 1. Findings include: The adult family home is licensed to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, advanced aged, developmentally disabled, traumatic brain injury, and terminally ill.	M 436		

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M 436	Continued From page 5 On 09/22/2026 at 11:58 AM, Surveyor received an email from Neighbor C. Attached to the email were videos captured by a door camera: -09/06/2026 12:33 PM- Resident 1 (alone in video) standing next to bush in front of front door, appears to unzip pants and urinate on bush (Footage 1) -09/09/2026 1:58 PM- Resident 1 (alone in video) approaches front door then turns around (Footage 2). -09/20/2026 3:24 PM- Resident 1 (alone in video) approaches front door, takes a few steps toward the right, leans forward toward the house, then leaves (Footage 3). The email stated " ...videos include one where [s/he] appears to urinate in our front yard and another when he is peering into our home ..." On 09/25/2026 at 6:30 PM, Surveyor received an email from Neighbor C stating " ...We have observed that the resident in question has cut through our backyard the last two days. He has come to our front door each of the last two days as well ..." On 09/29/2026 at 3:01 PM, Surveyor received an email from Neighbor C with a video attached. The video depicts a person opening Neighbor C's front door (from inside the house) as Resident 1 is approaching the front door (from outside). The person states to Resident 1 "Please go away, please go away, don't ever come here." Resident 1 turned around and left (Footage 4). The email stated " ...I wanted to share an interaction from today from 2:28 pm. We are not getting any relief from [his/her] visits and in this interaction the resident is indicating that [s/he] was just coming to see us. We have a sense that there may be some confusion on [his/her] side that is bringing [him/her] back to our home, rather than just	M 436		

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confusion of not knowing where [s/he] is or thinking our home is [his/her] home ..."

On 09/23/2026, Surveyor interviewed Neighbor C who stated his/her home is attached to the adult family home similar to a duplex but his/her front door is on the street around the corner from the adult family home's front door. Neighbor C stated Resident 1 had been on his/her property multiple times including 09/05/2026, 09/06/2026 twice, 09/09/2026, 09/13/2026, and 09/20/2026, and had knocked on his/her front door, urinated in his/her bushes, peered through the window, went into his/her back yard. Neighbor C stated s/he called the police who responded and said there was nothing they could do due to Resident 1's dementia. Neighbor C stated s/he had small children, they now keep their doors locked 24 hours per day, and s/he is worried they will be liable if Resident 1 gets hurt on his/her property.

On 10/02/2026 Surveyor arrived at the adult family home to conduct the investigation. Caregiver C was working alone.
On 10/02/2026 at 12:04 PM, Surveyor interviewed Caregiver C who stated s/he worked at the adult family home for 2 weeks, only on Fridays and this was his/her 2nd Friday working there. Caregiver C stated Resident 1 liked to walk outside but did not go far. Caregiver C stated s/he could not follow Resident 1 on his/her walks due to needing to stay with the other residents, but s/he watched Resident 1 walk outside from the window or front steps. Caregiver C stated s/he had told Resident 1 to not go the neighbor's house. Caregiver C stated Resident 1 was gone approximately 15 minutes at the most when out walking and when s/he told Resident 1 to come back into the house s/he did. Caregiver C stated if, during his/her walks, Resident 1 was gone for a

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long time and s/he could not see him/her, s/he would call Licensee A and follow Licensee A's instructions.

On 10/02/2026 at 12:12 PM, Surveyor interviewed Resident 1 who stated "A good while" when asked how long s/he lived at the home, and "Chicago" when asked what city we were in. Resident 1 stated s/he did not know which state we were in or the current month or year. When asked who the current president of the United States was s/he stated "I ain't seen him."

On 10/02/2026 at 12:17 PM, Surveyor observed a combination lock on the back yard fence gait and interviewed Caregiver C who stated the lock was put on the gait so Resident 1 would not leave the yard.

On 10/02/2026 8:56 PM, Surveyor received Resident 1's record from Licensee A via email. S/he was admitted 08/15/2026. Diagnoses included major cognitive disorder.
According to the National Library of Medicine: " ...The term major neurocognitive disorder (MNCD) (formerly known as dementia) is an umbrella that encompasses several disorders, including but not limited to Alzheimer's Disease (the most common, hence the most famous), vascular dementia, Lewy body dementia, frontotemporal dementia, and others...(Source: https://pmc.ncbi.nlm.nih.gov/articles/PMC12922723/ retrieval date 10/06/2026)).

Observation Notes:
08/16/2026- " ...[Resident 1] went for a walk to CVS and came back within 10 minutes and that is what he is doing throughout the day."
08/17/2026- " ...[Resident 1] went out 30 minutes after breakfast for a morning walk and came back

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within 10 to 20 minutes ..."
08/30/2026- " ...[Resident 1] went outside and sat with other residents. Afterwards, he went for a walk in the community and came back 10 to 30 minutes ..."
09/03/2026- " ...[Resident 1] went for a walk to CVS and came back within 10 minutes and that is what he is doing throughout the day. At a point, police officer arrived at the facility asking Dwayne if he happened to walk into our neighbor's property and Dwayne said no and told the police officer that I did not see him go that direction and later the police officer left ..."
09/17/2026- " ...[Resident 1] went out 30 minutes after breakfast for a morning walk and came back within 10 to 20 minutes ..."
09/30/2026- " ...[Resident 1] went out on a walk to CVS and came back within 10 to 30 minutes and continued doing that throughout the day ..."

ISP dated 09/04/2026-
In the area of Other: Major Neurocognitive Disorder- "Provide supervision and assistance as needed with activities of daily living, orientation, communication, safety ...Daily/each shift as appropriate ...Maintain the resident's highest possible level of independence, safety, orientation and functioning ..."

In the area of Nursing Procedures- "Requires supervision and support related to cognitive impairment, medication administration, hypertension monitoring and prevention of injury ...Daily and as needed ...provide orientation and reassurance ...Resident remains safe, comfortable and free from preventable injury ..."

In the area of Self Concepts- "Cognitive impairment may affect self-awareness, memory and ability to express needs ..."

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M 436	Continued From page 9 In the area of Maturation- "Resident has major neurocognitive disorder and benefits from a consistent routine, familiar approach, and support with decision making ..." In the area of Interaction with Others- "May benefit from encouragement and supervision to engage safely with staff and peers ..." In the area of Verbal- "Resident may have difficulty findings words, understanding complex directions, or recalling information due to neurocognitive disorder ..." In the area of Elopement- "Exit Seeking-Yes Major neurocognitive disorder places resident at risk for disorientation and exit-seeking. Requires a [sic] supervision and redirection. Monitor whereabouts routinely and during transitions, redirect calmy if resident approaches exits or attempts to leave. Resident remains safely within the facility and is free from elopement-related injury. Responsible person All staff and facility Manager ...Document exit-seeking episodes and interventions immediately. In the area of Leisure Time Activities- "Resident enjoys ...outings/shopping with adult family home staff ...assist with community outings as desired and appropriate ..." In the area of Community Contacts- "Resident benefits from contact with the case manager and participation in community outings with staff ...support community outings as desired ..." On 10/06/2026 at 9:26 AM, Surveyor interviewed [managed care organization (MCO)] Case Manager D who stated on 09/24/2026 s/he was	M 436		

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notified Resident 1 had wandered over to the neighbor's but was not aggressive but s/he was not aware Resident 1 went to the neighbors multiple times. Case Manager D stated it was not safe for Resident 1 to leave the property alone due to severe dementia. Case Manager D stated and a behavior support meeting was scheduled for 10/09/2026 at Gods Care and s/he had a meeting scheduled with a dementia specialist. Case Manager D stated Resident 1's Power of Attorney for Health Care document was activated on 10/13/2021 with Family Member E serving as agent.

On 10/06/2026 at 12:09 PM, Surveyor interviewed Licensee A who stated the MCO care managers told him/her prior to admission that Resident 1 liked going for walks, did not wander and always returned. Licensee A stated Resident 1 as not allowed to go to the neighbors but could not figure out how to get back because their kitchen sink window was close to the neighbor's deck. Licensee A stated when staff directed Resident 1 through the kitchen window, Resident 1 returned home and s/he explained to the neighbor that Resident 1 was confused. Licensee A stated staff did not go with Resident 1 when s/he left home because Resident 1 did not like to be followed and they were working with the MCO on getting 1 on 1 staff for him/her. Licensee A stated Resident 1 often went to the CVS store to buy snacks and would eat the snack at the CVS store, so time gone from home varied. Licensee A stated Resident 1 had "very obvious" cognitive impairment with episodes of orientation. Licensee A stated they made sure Resident 1 had oversite by staff watching him/her at the CVS store from their front door and if they did not see him/her at the store they would check his/her room and then the backyard. Licensee A stated s/he placed the

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M 436	Continued From page 11 lock on the backyard gate so the gate would appear locked to Resident 1. Licensee A stated s/he had updated the MCO each time Resident 1 went to the neighbors. Licensee A stated the county's adult protective services had come but told Licensee A they were doing everything they needed to do for Resident 1, and s/he knew the neighbors did not like Resident 1 going onto their property. Licensee A stated s/he had placed the yellow ribbon along the sidewalk in the front yard to deter Resident 1 from going toward the neighbor's property, monitored the GPS on Resident 1's wrist watch, and instructed staff to call 911 if Resident 1 was out of sight longer than the usual 30 minutes. On 10/08/2026 at 11:49 AM, Surveyor interviewed Family Member E who stated s/he thought staff and residents were leaving the property as a group and s/he did not think the CVS store could be seen from the front steps of the home because s/he could not see the home from the CVS store's parking lot the other day. Family Member E s/he bought Resident 1 a "boundaries" wrist watch with GPS tracker per Licensee A's request and Licensee A sent him/her an email on 10/06/2026 stating they would have a staff member follow Resident 1 when s/he leaves the property. Family Member E stated Resident 1 was still trying to get his/her bearings since being admitted in August 2026. Cross Reference: M0338 DHS 88.05(4)(c)1 Exiting From The First Floor M0504 DHS 88.09(1)(d)8 Resident Record-ISP	M 436		
M 504	88.09(1)(d)8 RESIDENT RECORD-ISP	M 504		

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(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 504	Continued From page 12 The individual service plan required under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on record review and staff interview, the adult family home did not maintain the individual service plan (ISP) at the home as required. Resident 1's ISP was not available to caregiving staff when Licensee A either took it from the home or locked it in the basement office. Findings include: The adult family home is licensed to serve up to 4 residents within the client groups of irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, advanced aged, developmentally disabled, traumatic brain injury, and terminally ill. On 10/02/2026 at 11:50 AM, Surveyor arrived at God's Care. Caregiver B was working alone. On 10/02/2026 at 11:54 AM Surveyor interviewed Licensee A (via phone) and asked where ISPs were kept in the home. Licensee A stated staff read the ISPs during their initial training then s/he takes the ISP "away" because previously the ISPs were kept in a drawer, but the residents tore them up. Surveyor requested Licensee A provide Surveyor Resident 1's record including the face sheet, current ISP, behavior support plan, managed care organization (MCO) contact information and observation notes since admission. On 10/02/2026 at 12:04 PM, Surveyor sent Licensee A a follow-up email requesting Resident	M 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019575	A. BUILDING: _____ B. WING _____	C 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GODS CARE	652 DAMASCUS TRL COTTAGE GROVE, WI 53527

(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 504	Continued From page 13 1's face sheet, current ISP, behavior support plan, MCO contact information and observation notes since admission. On 10/02/2026 at 12:04 PM, Surveyor interviewed Caregiver B who stated s/he only worked on Fridays and this was only his/her 2nd Friday working. On 10/02/2026 at 12:20 PM Surveyor and Caregiver B went into basement to check for an emergency exit. Surveyor asked what 1 of the doors led to, Caregiver B stated it was the office, tried to turn the doorknob and stated it was locked and s/he did not know how to unlock it. On 10/02/2026 at 8:56 PM, Surveyor received an email from Licensee A with attachments of the requested documentation. On 10/06/2026 at 12:09 PM, Surveyor discussed concern of no ISP available at the home for staff to reference with Licensee A who stated Resident 1's ISP was in his/her office in the basement and the office was locked. When Surveyor asked why the ISP was not available for staff to reference for provision of cares, Licensee A stated there was no place other than the office to keep the ISPs and Caregiver B had the spare office key. Cross Reference: M0436 DHS 88.07(2)(a) Services	M 504		