STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 04/22/2026, Surveyor conducted a standard survey and self-report review at Love Hope Faith Homes of WI LLC, an Adult Family Home (AFH) in West Bend, WI. Nine deficiencies identified. Census: 3	M 000		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each caregiver completed 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights, and treatment of residents for 1 of 1 employee requested who required annual training. Caregiver B did not receive 8 hours of annual continuing education training in calendar year 2025. Findings include: On 04/22/2026, Surveyor requested to review Caregiver B's record and identified the following:	M 246		

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
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 246	Continued From page 1 -Caregiver B was hired on 07/30/2024. -Caregiver B did not have any continuing education training for calendar year 2025. On 04/22/2026 at approximately 10:30 AM, Surveyor interviewed Manager A. Manager A stated s/he was not aware Caregiver B needed 8 hours of annual continuing education training. Manager A stated s/he would reach out to the facility nurse to help ensure all staff receive 8 hours of annual continuing education moving forward.	M 246		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure monthly smoke detector testing for 1 of 1 year reviewed. There was no evidence smoke detectors were checked in calendar year 2025. Findings include: On 04/22/2026 at approximately 10:00 AM, Surveyor reviewed safety records for the facility. There was no evidence of smoke detector testing	M 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 336	Continued From page 2 to date. On 04/22/206 at approximately 10:15 AM, Surveyor interviewed Manager A. Manager A stated s/he thought his/her maintenance person was documenting them but s/he only had the smoke detector/alarm system inspected annually and did not do the monthly smoke detector checks. Manager A stated s/he would make up a form to document them on a monthly basis moving forward. Cross Reference M0348 DHS 88.05(4)(d)2.c Semi-Annual Fire Drills	M 336		
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 been evaluated for evacuation time, using the department's form, since their admission. Findings include:	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 3 On 04/22/2026 at approximately 9:30 AM, Surveyor reviewed Resident 1 and Resident 2's records and identified the following: -Resident 1 was admitted to the provider's home on 07/31/2024. Resident 1's record did not include an evacuation assessment form since 07/31/2024. -Resident 2 was admitted to the provider's home on 07/31/2024. Resident 2's record did not include an evacuation assessment form since 07/31/2024. On 04/22/2026 at approximately 09:45 AM, Surveyor interviewed Manager A. Manager A stated s/he thought the evacuation only had to be completed upon admission and did not know it was an annual assessment. Manager A stated s/he did not update since their admission and would make sure moving forward all residents' evacuation assessments are completed upon admission and annually.	M 346		
M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a record of semi-annual fire drills conducted with all household members. The provider had 0 of 2 fire drills completed for calendar year 2025. Findings include:	M 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 348	Continued From page 4 On 04/22/2026 at approximately 10:00 AM, Surveyor reviewed the provider's records. Surveyor could not locate any fire drills being conducted for calendar year 2025. On 04/22/2026, at approximately 10:15 AM, Surveyor interviewed Manager A about fire drills. Manager A stated s/he thought s/he only had to evaluate the resident's evacuation time from the house. Manager A stated s/he was not aware there needed to be semi-annual fire drills conducted with the residents. Manager A stated s/he will come up with a form to start conducting semi-annual fire drills and document them on there moving forward. Cross Reference M0336 DHS 88.05(4)(b)2 Smoke Detectors- Testing and Maintenance	M 348		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the	M 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 380	Continued From page 5 provider did not ensure 3 of 3 residents (Resident 1, Resident 2 and Resident 3) reviewed received a health exam within 90 days prior to admission or within 7 days after admission. Findings include: On 04/22/2026 at approximately 09:30 AM, Surveyor reviewed Resident 1's, Resident 2's and Resident 3's records and identified the following: -Resident 1 was admitted to the facility on 07/31/2024. Resident 1's record did not include evidence of a health exam. -Resident 2 was admitted to the facility on 07/31/2024. Resident 2's record did not include evidence of a health exam. -Resident 3 was admitted to the facility on 08/01/2025. Resident 3's record did not include evidence of a health exam. On 04/22/2026 at approximately 10:00 AM, Surveyor interviewed Manager A. Manager A stated s/he was not aware they needed a health exam. Manager A stated s/he had all the residents get their TB skin test and communicable disease screenings but did not get an admission health exam within 90 days prior to admission or within 7 days after admission.	M 380		
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.	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 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, Resident 2 and Resident 3's ISP's did not include a signed statement of agreement with all parties involved. Findings include: On 04/22/2026, at approximately 9:30 AM, Surveyor reviewed resident records and identified the following concerns: -Resident 1 was admitted to the provider's home on 07/31/2024. Resident 1 has a health care power of attorney and a case manager. Surveyor reviewed ISP dated 02/17/2026. Resident 1's ISP did not have any signatures. -Resident 2 was admitted to the provider's home on 07/31/2024. Resident 2 is his/her own decision maker and a case manager. Surveyor reviewed ISP dated 02/17/2026. Resident 2's ISP did not have any signatures. -Resident 3 was admitted to the provider's home on 08/01/2025. Resident 3 has a health care power of attorney and a case manager. Surveyor reviewed ISP dated 02/23/2026. Resident 3's ISP did not have any signatures. On 04/22/2026 at approximately 10:30 AM, Surveyor interviewed Manager A. Manager A stated s/he just found out about a week ago from their facility nurse that all ISP's needed to be signed by all parties involved and s/he was not aware. Manager A stated s/he had just sent out the ISP's to all case managers and health care	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 7 power of attorney's for signatures and are waiting for them. Manager A stated s/he acknowledged ISP's needed to be signed by all parties involved in the ISP.	M 420		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update the Individual Service Plan (ISP) when there was a change in Resident 3's needs. Resident 3's ISP did not include information regarding his/her history of being sexually abused by another resident in the home and needing to be separated/not having contact with that resident.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 8 Findings include: On 04/06/2026, the Department received a self-report from the facility stating the following: -"Report Type: Alleged Abuse/Neglect-Immediate Reporting -Date of Incident: March 30,2026 -Law Enforcement notified: March 30,2026 -Report Prepared by: House Manager A -Individuals Involved: Alleged victim [Resident 3], Alleged Perpetrator [Resident 4]. -Incident Description: On March 30/2026 at approximately 8:09 AM, the writer received a message from [Resident 4] stating, "I'm hoping I could talk to you about [Resident 3] and what I do with [him/her] sometime today." The writer clarified the context and [Resident 4] indicated it involved both general and private interactions and requested confidentiality. At approximately 8:26 AM, [Resident 4] called and disclosed inappropriate sexual touching of [Resident 3], both over and under clothing. [Resident 4] admitted [Resident 3] appeared uncomfortable, pushed [his/her] hands away and that [s/he] continued despite resistance. [Resident 4] stated [s/he] did not know why [s/he] engaged in the behavior and reported apologizing afterward and asking [Resident 3] not to tell anyone. -Victim Statement: At approximately 9:06 AM on March 30, 2026, [Resident 3] confirmed that [Resident 4] touched [his/her] private area, including under clothing. [Resident 3] stated [s/he] does not like the behavior and tells [Resident 4] to stop, but [Resident 4] continues. [Resident 3] stated [s/he] did not report it because [Resident 4] is [his/her] friend and [s/he] did not want [him/her] to get into trouble. -Immediate Actions Taken: Ensured [Resident 3]'s safety and informed [him/her] the behavior	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 9	M 424		

would stop. [Resident 4] was immediately removed from the residence on March 30, 2026. [Parent] of [Resident 4] was informed [Resident 4] is not allowed contact with [Resident 3] or near the home. An emergency eviction noticed was issued to [Resident 4].
-Assessment: This incident constitutes alleged sexual abuse involving non-consensual contact, including continued behavior after refusal and physical resistance.
-Follow Up/Recommendations: Maintain separation and no-contact. Cooperate fully with law enforcement. Conduct internal investigation. Provide support to [Resident 3]. Continue documentation."

On 04/22/2026 at 9:30 AM, Surveyor reviewed Resident 3's record and identified the following:
-Resident 3 admitted 08/01/2025.
-Resident 3 has an activated Health Care Power of Attorney (POA).
-Resident 3's current ISP dated 02/23/2026 stated, "Interaction with others: Requires staff assistance and encouragement maintaining positive/appropriate interactions with others. Resident sometimes allow [his/her] friends/roommate to talk [him/her] into doing tasks that the friend should be doing. [S/he] needs reminders to speak up for [him/herself] and to say no when needed."

On 04/22/2026 at approximately 9:45 AM, Surveyor interviewed House Manager A. House Manager A stated s/he is not the one who would have assessed and updated the ISP for Resident 3. House Manager A called Registered Nurse (RN) C and put him/her on speaker phone. RN C stated s/he was responsible for conducting an assessment and updating the ISP. RN C stated s/he did not think to update the ISP with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 10 history of Resident 3 being sexually abused by Resident 4. House Manager A and RN C stated they asked Resident 3 if s/he wanted therapy but s/he denied it at that time but understood why it would be important to update his/her ISP with the history of sexual abuse and that Resident 3's POA did not want Resident 3 to have any contact with Resident 4 until the investigation was final. RN C stated s/he would update the ISP immediately.	M 424		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician for 3 of 3 residents reviewed who required staff to administer their medications. Resident 1, Resident 2 and Resident 3 did not have a written order permitting the provider staff to administer medications. Findings include:	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 464	Continued From page 11 On 04/22/2026 at 9:30 AM, Surveyor reviewed Resident 1's, Resident 2's and Resident 3's records and identified the following: -Resident 1 was admitted to the facility on 07/31/2024. Resident 1 did not have evidence of written orders from his/her physician permitting the provider staff to administer his/her medications. -Resident 2 was admitted to the facility on 07/31/2024. Resident 2 did not have evidence of written orders from his/her physician permitting the provider staff to administer his/her medications. -Resident 3 was admitted to the facility on 08/01/2025. Resident 3 did not have evidence of written orders from his/her physician permitting the provider staff to administer his/her medications. On 04/22/2026 at 10:00 AM, Surveyor interviewed House Manager A. House Manager A reported Resident 1, Resident 2 and Resident 3 required provider staff to administer their medication. House Manager A stated s/he was unaware they needed a written order permitting the provider staff to administer medications. House Manager A stated moving forward, s/he would ensure each resident in the home had a written order from his/her physician permitting the provider staff to administer the medications.	M 464		
M 510	88.09(1)(d)11 RESIDENT FUNDS Records maintained by the licensee of the resident's finances, including written authorization from the resident of resident's guardian to control the resident's funds.	M 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 510	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure, for 3 of 3 residents (Resident 1, Resident 2 and Resident 3), to include written authorization from the resident and/or legal guardian to control the resident's funds. Finding include: The facility received a regular license on 10/11/2023, to serve up to 4 residents within the client groups: public funding, advanced age,developmentally disabled, emotionally disturbed/mental illness and irreversible dementia/Alzheimer's. On 04/22/2026, Surveyor reviewed Resident 1's, Resident 2's and Resident 3's records and identified the following: -Resident 1 was admitted to the home on 07/31/2024 with no evidence of written authorization to control resident funds. -Resident 2 was admitted to the home on 07/31/2024 with no evidence of written authorization to control resident funds. -Resident 3 was admitted to the home on 08/01/2025 with no evidence of written authorization to control resident funds. On 04/22/2026 at approximately 10:45 AM, Surveyor interviewed House Manager A. House Manager A stated the facility did control and manage Resident 1's, Resident 2's, and Resident 3's funds. House Manager A stated they each get a certain allowance for each month and they either have physical cash or they use a debit card but they handle the cash and debit cards for the	M 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019587	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE HOPE FAITH HOMES OF WI LLC	1310 S 7TH AVENUE WESTBEND, WI 53095

(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 510	Continued From page 13 residents. House Manager A stated s/he was not aware they needed authorization. House Manager A stated s/he would get a form filled out to get authorization from the resident or resident's power of attorney as soon as possible.	M 510		