

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/15/2026
NAME OF PROVIDER OR SUPPLIER COMPASSIONATE ADULT FAMILY HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6935 W PIONEER RD MEQUON, WI 53097		
(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 07/13/2026, Surveyors conducted three (3) complaint investigations at Compassionate Adult Family Home LLC, Mequon. Additional information was gathered through 07/15/2026. As a result of the survey 3 complaints were substantiated, resulting in 9 deficiencies. One (1) of 9 deficiency was a repeat violation. Census: 1	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not report to the Department a significant change in resident status for 1 of 1 resident. One of 1 resident eloped and was returned to the facility by law enforcement. These incidents were not reported to the Department. Resident 2 eloped 6 times that were not self-reported to the Bureau.	M 134		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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M 134	Continued From page 1 This is a repeat deficiency. See statement of deficiency (SOD) VOSA13, 10/22/2025. Findings include: On 05/21/2026 and 06/17/2026 the Bureau received complaints alleging resident elopements. On 07/13/2026, Surveyors reviewed police reports from the Cedarburg Police Department and the Mequon Police Department. * Cedarburg Police Reports show Resident 2 eloped on 04/13/2026, 05/13/2026, 06/06/2026, 06/14/2026, 06/15/2026 and 06/17/2026. On 07/13/2026, Surveyors reviewed the facility folder. There were no self-reports filed for Resident 2's elopements on 04/13/2026, 05/13/2026, 06/06/2026, 06/14/2026, 06/15/2026 and 06/17/2026. Surveyors observed a self-report filed on 05/31/2026, when Resident 2 was left unattended at home. On 07/13/2026 at 7:20 AM, Surveyors interviewed Caregiver C. Caregiver C confirmed Resident 2 had both eloped from the facility and the police were called. On 07/13/2026 at 8:10 AM, Surveyors requested Resident 2's record from Licensee A. Resident 2 was admitted to the facility 06/2025 with diagnoses to include autism, bipolar, ADHD and Tourette's. Resident 2's individual service plan (ISP) reflected Resident 2 was a 1:1 staffing. On 07/13/2026 at 9:30 AM, Surveyors interviewed Licensee A. Licensee A stated s/he had not submitted a self-report for Resident 2's	M 134			

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M 134	Continued From page 2 elopement. Licensee A stated when Resident 2 eloped staff were following him/her and never lost sight. Surveyors shared the report the Bureau received on 05/31/2026, but there were no other self-reports filed. Surveyors shared the police reports on 04/13/2026, 05/13/2026, 06/06/2026, 06/14/2026, 06/15/2026, 06/17/2026 for Resident 2, and that the police reports reflect no staff present and police returned the residents to the house. Surveyors stated the elopements were not self-reported with 24 hours. Licensee A confirmed s/he had not submitted the self-reports, as s/he did not understand the code. The licensee did not report to the Department the elopements for 1 of 1 residents. Cross Reference M0216 DHS 88.04(2)(a) Responsibilities Cross Reference M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm Cross Reference M0424 DHS 88.06(3)(f) Review of ISP	M 134		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the provider, and its operation complied with all laws governing an Adult Family Home (AFH). Findings include:	M 216		

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M 216	Continued From page 3 The facility is licensed to provide care for up to 4 residents who may be emotionally disturbed/mental illness, physically disabled, pregnant women/counseling, advanced age, developmentally disabled, alcohol/drug dependent, traumatic brain injury, correctional clients, terminally ill and/or irreversible dementia/Alzheimer's. On 07/13/2026, at 7:00 AM, Surveyors arrived at the facility to investigate 3 complaints. Surveyors rang the doorbell and knocked with no answer. Surveyors observed all windows in the house and garage to be covered. Surveyors called Licensee A's phone number and left a message. At 7:42 AM, Licensee A returned call to Surveyors. At 8:05 AM Licensee A arrived at the facility. Licensee A stated there was not anyone currently home. Licensee A stated Resident 2 had moved out and Resident 1 left with family yesterday, 07/12/2026, and s/he had not returned to the facility. Licensee A was unable to provide Surveyors with Resident 1's family name or contact number, as s/he did not have. N134 DHS 88.06(5)(e)1 Significant Change To Resident Based on record review and interview, the licensee did not report to the Department a significant change in resident status for 1 of 1 resident. One of 1 resident eloped and was returned to the facility by law enforcement. These incidents were not reported to the Department. Resident 2 eloped 6 times that were not self-reported to the Bureau. This is a repeat deficiency. See statement of	M 216		

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M 216	Continued From page 4 deficiency (SOD) VOSA13, 10/22/2025. N216 DHS 88.04(2)(a) Responsibilities Based on record review and interview, the licensee did not ensure the provider, and its operation complied with all laws governing an Adult Family Home (AFH). N218 DHS 88.04(2)(b) Awake Staff For Continuous Care Based on record review and interview, the provider did not ensure there was an awake staff at all times when a resident required continuous care for Resident 1. - Resident 1 required 24/7 continuous staffing. Licensee A reported s/he worked 24 hours a day for approximately 1 week. Licensee A could not verify how awake staffing was maintained during that time. N230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm Based on observation, record review and interview, the licensee permitted the existence or continuation of conditions in the home which placed the health, safety and welfare of residents at substantial risk of harm for Resident 1 and Resident 2. Resident 1 was protectively placed and had guardian. Resident 1's member-centered plan stated s/he required 24-hour supervision, including overnights. Resident 1 was not present during the survey on 07/13/2026. Licensee A advised Resident 1 was with his/her family on 07/12/2026 and decided to spend the night. Resident 1 did not have his/her medications and missed the evening doses on 07/12/2026 and morning doses on 07/13/2026. Licensee A had no address or phone contact information for the	M 216		

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M 216	Continued From page 5 family member. Resident 1's corporate guardian confirmed s/he was not aware of the unsupervised away from home/overnight visit. The corporate guardian stated this was not discussed or approved. Licensee A advised s/he worked at the home for 24 hours a day the last week with Resident 1. Licensee A could not verify how awake staffing was provided to Resident 1 during the timeframe. Resident 2 was protectively placed and had a guardian. Resident 2's behavior support plan stated upon elopement, caregivers should follow and keep him/her in line of sight. Resident 2 eloped on 6 times. Each elopement resulted in the police department locating Resident 2 with no caregiver present. N276 DHS 88.05(3)(a) Home Like Environment Based on observation and interview, the provider did not ensure the adult family home was well-maintained and provided a homelike environment for 1 of 1 resident. N424 DHS88.06(3)(f) Review of ISP Based on record review and interview, the provider did not ensure the individual service plan (ISP) was updated whenever the residents' needs changed for Resident 1 and Resident 2. - Resident 1's ISP was not updated to reflect a change in the level of supervision needed. - Resident 2's ISP was not updated to reflect elopement interventions. Resident 2 eloped from the facility 6 times. N550 DHS 88.10(3)(b) Privacy Based on observation and interview, the provider did not ensure 2 of 2 residents had privacy in their own home.	M 216		

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M 216	Continued From page 6 N582 DHS 88.10 (3)(q) Medications Based on record review, interview and observation, the provider did not ensure residents received medications as they were prescribed for Resident 1. - Resident 1 was protectively placed and had a corporate guardian. Resident 1 stayed overnight at a family member's house and the Licensee did not ensure Resident 1 had his/her medications. 0023 50.65(4m)(b) Caregiver Hiring and Contracting Process Based on record review and interview, the facility permitted Caregiver B to work in the home when Caregiver B had a barred offense. - Caregiver B was charged with aggravated battery 940.19(6) Cross Reference Z0023 DHS 50.065(4m)(b) Caregiver Hiring and Contracting Process Cross Reference M0134 DHS 88.03(5)(e)(1) Significant Change To The Resident Cross Reference M0218 DHS 88.04(2)(b) Awake Staff for Continuous Care Cross Reference M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm Cross Reference M0276 DHS 88.05(3)(a) Homelike Environment Cross Reference M0424 DHS 88.06(3)(f) Review of ISP Cross Reference M0582 88.10(3)(q) Medications	M 216			
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident	M 218			

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M 218	Continued From page 7 is in need of continuous care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there was an awake staff at all times when a resident required continuous care for Resident 1. Resident 1 required 24/7 continuous staffing. Licensee A reported s/he worked 24 hours a day for approximately 1 week. Licensee A could not verify how awake staffing was maintained during that time. Findings Include: On 05/21/2026 and 06/17/2026 the Bureau received complaints alleging inadequate supervision. Interview with Licensee A On 07/13/2026, at 9:01 AM, Surveyors interviewed Licensee A regarding staffing at the adult family home. Licensee A advised since Resident 1 is the only resident at the home, there are only 2 caregivers, Licensee A and Caregiver D. Licensee A reported Caregiver D was on vacation the previous week and Licensee A was working 24 hours a day with Resident 1. Surveyors inquired if Resident 1 could be unsupervised during sleep hours as it would be difficult to work 24 hours a day for a week. Licensee A responded by explaining Resident 1 no longer required a 1:1 level of supervision. Licensee A again confirmed s/he was the only caregiver working with Resident 1 the previous week. Additionally, Licensee A stated Resident 1 could leave the home unsupervised for short distances and go to work. Surveyors requested	M 218			

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M 218	Continued From page 8 staff schedules from Licensee A. Licensee A stated s/he had schedules on his/her computer at his/her house. Licensee A stated s/he would send to Surveyors by end of the day. On 07/14/2026 at 8:23 AM, Surveyors emailed Licensee A and asked for him/her to provide the staff schedule by 11:00 AM, 07/14/2026. At 12:26 PM, Surveyors sent a second email to Licensee A requesting information. As of 07/15/2026 at 12:00 PM, Surveyors did not receive any additional information from Licensee A. Interview with Guardian F On 07/15/2026, at 10:35 AM, Surveyors interviewed Guardian F. Guardian F identified s/he has been Resident 1's corporate guardian for approximately 2 years and confirmed s/he is protectively placed. Guardian F reported Resident 1 should have awake staff overnight and should not leave the home unsupervised unless it is to go to work at Piggly Wiggly. Assessment On 07/08/2026, Surveyor reviewed Resident 1's assessment dated 04/08/2024. The assessment identified Resident 1 required "24-hour direct supervision." Member Centered Plan 06/01/2026 On 07/13/2026, Surveyor reviewed Resident 1's most current MCP dated 06/01/2026. The MCP noted the following: Resident 1 required "24/7 care and supervision ...overnight care/supervision ..." Resident 1 required "full assist" medication administration due to cognition Resident 1's had a history of the following	M 218		

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M 218	Continued From page 9 behaviors: "cutting self with broken glass or other found sharp objects, swallowing non-food items." Description of behaviors were, "verbal threats, combativeness toward staff, and property damage." Individual Support Plan On 07/13/2026, Surveyors reviewed Resident 1's individual support plan (ISP), dated 05/08/2025. The ISP noted Resident 1 was admitted in April 2024 with the following diagnosis: borderline intellectual functioning, anxiety disorder, post-traumatic stress disorder, impulse disorder, disruptive mood disorder, reactive attachment disorder of childhood, psychotic disorder with delusions due to known physiological, attention-deficit hyperactivity disorder and schizoaffective disorder. The ISP further identified: >Resident 1 required assistance with medication administration >The ISP did not identify the level of supervision Resident 1 required. According to Resident 1's MCP, ISP and Guardian F, Resident 1 should have continuous awake staff 24/7. Licensee A reported s/he worked 24 hours a day for the previous week. Licensee A did not provide any supporting evidence to show there was awake staffing during this time. Cross Reference M0216 DHS 88.04(2)(a) Responsibilities Cross Reference M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm Cross Reference M0424 DHS 88.06(3)(f) Review of ISP	M 218		

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M 230	Continued From page 10	M 230			
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, record review and interview, the licensee permitted the existence or continuation of conditions in the home which placed the health, safety and welfare of residents at substantial risk of harm for Resident 1 and Resident 2. Resident 1 was protectively placed and had guardian. Resident 1's member-centered plan stated s/he required 24-hour supervision, including overnights. Resident 1 was not present during the survey on 07/13/2026. Licensee A advised Resident 1 was with his/her family on 07/12/2026 and decided to spend the night. Resident 1 did not have his/her medications and missed the evening doses on 07/12/2026 and morning doses on 07/13/2026. Licensee A had no address or phone contact information for the family member. Resident 1's corporate guardian confirmed s/he was not aware of the unsupervised away from home/overnight visit. The corporate guardian stated this was not discussed or approved. Licensee A advised s/he worked at the home for 24 hours a day the last week with Resident 1. Licensee A could not verify how awake staffing was provided to Resident 1 during the timeframe. Resident 2 was protectively placed and had a	M 230			

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M 230	Continued From page 11 guardian. Resident 2's behavior support plan stated upon elopement, caregivers should follow and keep him/her in line of sight. Resident 2 eloped on 6 times. Each elopement resulted in the police department locating Resident 2 with no caregiver present. Findings include: On 05/21/2026 and 06/17/2026 the Bureau received complaints alleging inadequate supervision. On 07/13/2026 at 9:00 AM, Surveyors requested staff schedules from Licensee A. Licensee A stated s/he had schedules on his/her computer at his/her house. Licensee A stated s/he would send to Surveyors by end of the day. Surveyors shared staffing requirements as Resident 1 and Resident 2 were 1:1. Licensee A stated Resident 2 was the only 1:1 s/he had, and that the managed care provider would not pay for a 1:1 for Resident 1. On 07/14/2026 at 8:23 AM, Surveyors emailed Licensee A and asked for him/her to provide the staff schedule by 11:00 AM, 07/14/2026. At 12:26 PM, Surveyors sent a second email to Licensee A requesting information. As of 07/15/2026 at 12:00 PM, Surveyors did not receive any additional information from Licensee A. RESIDENT 1 Interview with Licensee A On 07/13/2026 at 8:05 AM, Surveyors entered the home to conduct three complaint investigations. Licensee A advised Resident 1 was out with	M 230		

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M 230	Continued From page 12 family. Licensee A reported Resident 1 went with his/her family member yesterday (07/12/2026). Licensee A explained Resident 1 did not return home because s/he wanted to spend the night with the family member. Licensee A stated s/he was picking Resident 1 up from his/her family member's house today (07/13/2026) at 10:00 AM for an 11:00 AM lab appointment. Licensee A could not provide any contact information for the family member or definitively identify Resident 1's whereabouts. Licensee A stated s/he did not have the address or phone number for the family member. Licensee A clarified s/he would obtain the contact information when the family member texted him/her later that morning. Licensee A confirmed Resident 1 did not take any of his/her medications and missed his/her evening medications for 07/12/2026 and morning medications for 07/13/2026. Surveyors inquired about contact information for Resident 1's family member, Licensee A confirmed s/he was unaware of Resident 1's location. Surveyors tried calling Resident 1's cell phone, phone was turned off. Surveyors inquired about staffing for the home. Licensee A reported that since Resident 2 moved out, there are only 2 caregivers that work at the home, Licensee A and Caregiver D. Licensee A reported Caregiver D was on vacation the previous week and Licensee A was working 24 hours a day with Resident 1. Surveyors inquired if Resident 1 could be unsupervised during sleep hours as it would be difficult to work 24 hours a day for a week. Licensee A responded by explaining Resident 1 no longer required a 1:1 level of supervision. Licensee A again confirmed s/he was the only caregiver working with Resident 1 the previous week.	M 230			

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M 230	Continued From page 13 Assessment On 07/08/2026, Surveyor reviewed Resident 1's assessment dated 04/08/2024. The assessment identified Resident 1 required "24-hour direct supervision." Member Centered Plan 06/01/2026 On 07/13/2026, Surveyor reviewed Resident 1's most current MCP dated 06/01/2026. The MCP noted the following: Resident 1 required "24/7 care and supervision ...overnight care/supervision ..." Resident 1 required "full assist" medication administration due to cognition Resident 1's had a history of the following behaviors: "cutting self with broken glass or other found sharp objects, swallowing non-food items." Description of behaviors were, "verbal threats, combativeness toward staff, and property damage." Individual Support Plan On 07/13/2026, Surveyors reviewed Resident 1's individual support plan (ISP), dated 05/08/2025. The ISP noted Resident 1 was admitted in April 2024 with the following diagnosis: borderline intellectual functioning, anxiety disorder, post-traumatic stress disorder, impulse disorder, disruptive mood disorder, reactive attachment disorder of childhood, psychotic disorder with delusions due to known physiological, attention-deficit hyperactivity disorder and schizoaffective disorder. The ISP further identified: >Resident 1 required assistance with medication administration >The ISP did not identify the level of supervision	M 230		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/15/2026
NAME OF PROVIDER OR SUPPLIER COMPASSIONATE ADULT FAMILY HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6935 W PIONEER RD MEQUON, WI 53097		
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M 230	Continued From page 14 Resident 1 required. On 07/13/2026, at 8:16 AM, Surveyors observed Resident 1's medications were in the locked medication drawer. Observation of the medications confirmed the pills for the evening of 07/12/2026 and the morning of 07/13/2026 were still in the bubble pack. Medications observed still in the bubble pack were as follows: 07/13/2026 Morning/AM dose observed in bubble pack Multi-vit/min (certavite) - take 1 tablet twice daily Bupropion XL 300mg - take 1 tab daily for depression Topiramate 50mg - take 1 tab twice daily Aspirin 81mg CHW - chew and swallow 1 tab daily Levothyroxine 25mcg - take 1 tab daily for hypothyroid Lamotrigine 150mg - take 1 tab twice daily (morning and evening) for seizures VIT D2 50,000U - take 1 cap by mouth one time weekly 07/12/2026 Evening/PM dose observed in bubble pack Multi-vit/min (certavite) - take 1 tablet twice daily Clonidine 0.1mg - take 1 tab by mouth every evening for anxiety Trazodone 100mg - take 1 tab once daily at bedtime Cyclobenzaprine 5mg - take 1 tab at bedtime Quetiapine 100mg - take 1 tab daily at bedtime Gabapentin 300mg - take 1 cap daily at bedtime Lamotrigine 150mg - take 1 tab twice daily (morning and evening) for seizures Topiramate 50mg - take 1 tab twice daily Surveyor Note: The July 2026 MAR was not	M 230			

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M 230	Continued From page 15 present for review. Interview with Guardian F On 07/15/2026, at 10:35 AM, Surveyors interviewed Guardian F. Guardian F identified s/he has been Resident 1's corporate guardian for approximately 2 years and confirmed s/he is protectively placed. Guardian F explained that any type of away from home or overnight visit would need to be discussed and approved prior to occurring. Guardian F verified neither Licensee A or Resident 1 ever mentioned Resident 1 going with family members or spending the night. Guardian F stated s/he was not aware of Resident 1 being away from the adult family home on 07/12/2026 and 07/13/2026. Guardian F described the importance of Resident 1 to take his/her medications as s/he just got out of treatment on 06/22/2026 for suicidal ideations. Guardian F reported Resident 1 should not leave the home unsupervised unless it is to go to work at Piggly Wiggly. Resident 1 was protectively placed and had a corporate guardian. Resident 1 was not at the adult family home during the survey. Licensee A stated Resident 1 spent the night with his/her family but could not identify where the family member lived or any contact information. Licensee A confirmed Resident 1 did not take his/her medication on the evening of 07/12/2026 or the morning of 07/13/2026. According to Resident 1's corporate guardian, s/he was unaware that Resident 1 was leaving the home unsupervised with no discussion or approval. After leaning Licensee A worked approximately 1 week at 24 hours a day with Resident 1, Surveyors inquired what Resident 1's overnight level of supervision looked like as it would be difficult to stay awake that long. Licensee A only	M 230			

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M 230	Continued From page 16 responded s/he is not a 1:1 anymore. Licensee A did not provide a staffing schedule. RESIDENT 2 Interview with Licensee A On 07/13/2026, at approximately 8:15 AM, Surveyors interviewed Licensee A. Licensee A stated Resident 2 moved out in early July 2026 and confirmed s/he required a 1:1 level of supervision. Licensee A stated the caregivers could always see Resident 2 when s/he eloped. Surveyors discussed the content of the police reports showing a caregiver was not present with Resident 2 when police located him/her. Licensee A continued to say caregivers knew Resident 2's whereabouts. Police Reports On 07/13/2026, Surveyor reviewed police reports. The reports showed Resident 2 eloped from the home on 6 occasions. 04/13/2026 at 3:38 PM: Resident 2 eloped to a dentist's office "Resident from the group home wandered over and is sitting in their lobby ...convinced [him/her] to return to the home without further incident ..." 05/31/2026 at 3:39 PM: Resident 2 eloped to a neighbor's house "Caller reporting a [gender] in front of [his/her] house. May need help ...very confused asking for water ..." The report identified this as Resident 2. " ...[Resident 2] was ultimately transported voluntarily back to [his/her] group home ...standing by until caregiver arrives ETA (estimated time off arrival) 5 minutes ..."	M 230			

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M 230	Continued From page 17 06/06/2026 at 12:38 AM: Resident 2 ran out and whereabouts were unknown " ...shorts, tank top, poss (possibly) a robe ...UNK (unknown) places [s/he] likes to go ..." Resident 2 was found in the driveway by police. 06/14/2026 at 5:41 PM: Resident 2 and Person G left the home located by police "[Resident 2] and [Person G] both eloped ...both left opposite directions ...HO [home owner] ...Partridge Ct advising they are out with [Resident 2] in the backyard ...[Resident 2] and [Person G] were both located and returned to the group home ...[Caregiver B] was on scene to take custody of both subjects." 06/15/2026 at 3:15 AM: Resident 2 eloped to neighbor's house "Someone ringing doorbell. Barefoot [gender] ...states the [gender] is saying that [s/he's] lost ...POI (Person of Interest) has been at the front door for 5 mins (minutes). Is still ringing doorbell ...POI is looking into the house ...[S/he] was given a ride back to the home and staff member informed about the incident ..." 06/17/2026 at 4:07 PM: Resident 2 eloped to dentist's office "[Resident 2] is on scene, ran away from group home ...sitting in lobby. Said someone was trying to attack [him/her] ...assisted [Resident 2] with getting into the house ..." All six police reports reflected they located Resident 2 with no caregiver present and returned Resident 2 to his/her home. Behavior Support Plan On 07/08/2026, Surveyor reviewed Resident 2's	M 230		

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M 230	Continued From page 18 behavior support plan dated 06/05/2025. The BSP noted the following: Behaviors: Verbal aggression, self-injurious behavior, property destruction and elopements. The BSP had specific instructions should Resident 2 elope as follows: -elopement bag should be by the front exit and contain water, snacks, hand pads for blocking, flashlight and facesheet. -Upon elopement, staff should grab the bag, follow him/her and always maintain line of sight. Individual Support Plan 12/10/2025 On 07/08/2026, Surveyor reviewed Resident 2's ISP dated 12/10/2025. The ISP noted Resident 2 was protectively placed and had a legal guardian. The ISP specified the following: Level of Supervision: 1:1 dedicated staffing 24/7 Behaviors: Aggressive behaviors, self-injurious behaviors, sexually motivated behaviors, property destruction and elopement attempts. Resident 2 required a 1:1 level of supervision. According to Resident 2's BSP, upon elopement, caregivers were to follow Resident 2 and keep him/her within line of sight. Review of the police reports showed the police located Resident 2 with no caregivers present. There was no evidence to show Resident 2 was provided the 1:1 level of supervision when s/he eloped. On 05/21/2026 and 06/17/2026 the Bureau received complaints alleging inadequate supervision. On 07/13/2026 at 9:00 AM, Surveyors requested staff schedules from Licensee A. Licensee A stated s/he had schedules on his/her computer at his/her house. Licensee A stated s/he would send to Surveyors by end of the day. Surveyors	M 230			

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M 230	Continued From page 19 shared staffing requirements as Resident 1 and Resident 2 were 1:1 and Resident 3 was 24/7 supervision. Licensee A stated Resident 2 was the only 1:1 s/he had, and that the managed care provider would not pay for a 1:1 for Resident 1. On 07/14/2026 at 8:23 AM, Surveyors emailed Licensee A and asked for him/her to provide the staff schedule by 11:00 AM, 07/14/2026. At 12:26 PM, Surveyors sent a second email to Licensee A requesting information. As of 07/15/2026 at 12:00 PM, Surveyors did not receive any additional information from Licensee A. RESIDENT 1 Interview with Licensee A On 07/13/2026 at 8:05 AM, Surveyors entered the home to conduct three complaint investigations. Licensee A advised Resident 1 was out with family. Licensee A reported Resident 1 went with his/her family member yesterday (07/12/2026). Licensee A explained Resident 1 did not return home because s/he wanted to spend the night with the family member. Licensee A stated s/he was picking Resident 1 up from his/her family member's house today (07/13/2026) at 10:00 AM for an 11:00 AM lab appointment. Licensee A could not provide any contact information for the family member or definitively identify Resident 1's whereabouts. Licensee A stated s/he did not have the address or phone number for the family member. Licensee A clarified s/he would obtain the contact information when the family member texted him/her later that morning. Licensee A confirmed Resident 1 did not take any of his/her medications and missed his/her evening medications for 07/12/2026 and morning	M 230			

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M 230	Continued From page 20 medications for 07/13/2026. Surveyors inquired about contact information for Resident 1's family member. Surveyors inquired about staffing for the home. Licensee A reported that since Resident 2 moved out, there are only 2 caregivers that work at the home, Licensee A and Caregiver D. Licensee A reported Caregiver D was on vacation the previous week and Licensee A was working 24 hours a day with Resident 1. Surveyors inquired if Resident 1 could be unsupervised during sleep hours as it would be difficult to work 24 hours a day for a week. Licensee A responded by explaining Resident 1 no longer required a 1:1 level of supervision. Licensee A again confirmed s/he was the only caregiver working with Resident 1 the previous week. Assessment On 07/08/2026, Surveyor reviewed Resident 1's assessment dated 04/08/2024. The assessment identified Resident 1 required "24-hour direct supervision." Member Centered Plan 06/01/2026 On 07/13/2026, Surveyor reviewed Resident 1's most current MCP dated 06/01/2026. The MCP noted the following: Resident 1 required "24/7 care and supervision ...overnight care/supervision ..." Resident 1 required "full assist" medication administration due to cognition Resident 1's had a history of the following behaviors: "cutting self with broken glass or other found sharp objects, swallowing non-food items." Description of behaviors were, "verbal threats, combativeness	M 230			

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M 230	Continued From page 21 toward staff, and property damage." Individual Support Plan On 07/13/2026, Surveyors reviewed Resident 1's individual support plan (ISP), dated 05/08/2025. The ISP noted Resident 1 was admitted in April 2024 with the following diagnosis: borderline intellectual functioning, anxiety disorder, post-traumatic stress disorder, impulse disorder, disruptive mood disorder, reactive attachment disorder of childhood, psychotic disorder with delusions due to known physiological, attention-deficit hyperactivity disorder and schizoaffective disorder. The ISP further identified: >Resident 1 required assistance with medication administration >The ISP did not identify the level of supervision Resident 1 required. On 07/13/2026, at 8:16 AM, Surveyors observed Resident 1's medications were in the locked medication drawer. Observation of the medications confirmed the pills for the evening of 07/12/2026 and the morning of 07/13/2026 were still in the bubble pack. Medications observed still in the bubble pack were as follows: 07/13/2026 Morning/AM dose observed in bubble pack Multi-vit/min (certavite) - take 1 tablet twice daily Bupropion XL 300mg - take 1 tab daily for depression Topiramate 50mg - take 1 tab twice daily Aspirin 81mg CHW - chew and swallow 1 tab daily Levothyroxine 25mcg - take 1 tab daily for hypothyroid Lamotrigine 150mg - take 1 tab twice daily	M 230		

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M 230	Continued From page 22 (morning and evening) for seizures VIT D2 50,000U - take 1 cap by mouth one time weekly 07/12/2026 Evening/PM dose observed in bubble pack Multi-vit/min (certavite) - take 1 tablet twice daily Clonidine 0.1mg - take 1 tab by mouth every evening for anxiety Trazodone 100mg - take 1 tab once daily at bedtime Cyclobenzaprine 5mg - take 1 tab at bedtime Quetiapine 100mg - take 1 tab daily at bedtime Gabapentin 300mg - take 1 cap daily at bedtime Lamotrigine 150mg - take 1 tab twice daily (morning and evening) for seizures Topiramate 50mg - take 1 tab twice daily Surveyor Note: The July 2026 MAR was not present for review. Interview with Guardian F On 07/15/2026, at 10:35 AM, Surveyors interviewed Guardian F. Guardian F identified s/he has been Resident 1's corporate guardian for approximately 2 years and confirmed s/he is protectively placed. Guardian F explained that any type of away from home or overnight visit would need to be discussed and approved prior to occurring. Guardian F verified neither Licensee A or Resident 1 ever mentioned Resident 1 going with family members or spending the night. Guardian F stated s/he was not aware of Resident 1 being away from the adult family home on 07/12/2026 and 07/13/2026. Guardian F described the importance of Resident 1 to take his/her medications as s/he just got out of treatment on 06/22/2026 for suicidal ideations. Guardian F reported Resident 1 should not leave the home unsupervised unless it is to go to work	M 230			

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M 230	Continued From page 23 at Piggly Wiggly. Resident 1 was protectively placed and had a corporate guardian. Resident 1 was not at the adult family home during the survey. Licensee A stated Resident 1 spent the night with his/her family but could not identify where the family member lived or any contact information. Licensee A confirmed Resident 1 did not take his/her medication on the evening of 07/12/2026 or the morning of 07/13/2026. According to Resident 1's corporate guardian, s/he was unaware that Resident 1 was leaving the home unsupervised with no discussion or approval. After leaning Licensee A worked approximately 1 week at 24 hours a day with Resident 1, Surveyors inquired what Resident 1's overnight level of supervision looked like as it would be difficult to stay awake that long. Licensee A only responded s/he is not a 1:1 anymore. Licensee A did not provide a staffing schedule. RESIDENT 2 Interview with Licensee A On 07/13/2026, at approximately 8:15 AM, Surveyors interviewed Licensee A. Licensee A stated Resident 2 moved out in early July 2026 and confirmed s/he required a 1:1 level of supervision. Licensee A stated the caregivers could always see Resident 1 when s/he eloped. Surveyors discussed the content of the police reports showing a caregiver was not present with Resident 1 when police located him/her. Licensee A continued to say caregivers knew Resident 2's whereabouts. Police Reports	M 230		

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M 230	Continued From page 24 On 07/13/2026, Surveyor reviewed police reports. The reports showed Resident 2 eloped from the home on 6 occasions. 04/13/2026 at 3:38 PM: Resident 2 eloped to a dentist's office "Resident from the group home wandered over and is sitting in their lobby ...convinced [him/her] to return to the home without further incident ..." 05/31/2026 at 3:39 PM: Resident 2 eloped to a neighbor's house "Caller reporting a [gender] in front of [his/her] house. May need help ...very confused asking for water ..." The report identified this as Resident 2. "...[Resident 2] was ultimately transported voluntarily back to [his/her] group home ...standing by until caregiver arrives ETA (estimated time off arrival) 5 minutes ..." 06/06/2026 at 12:38 AM: Resident 2 ran out and whereabouts were unknown "...shorts, tank top, poss (possibly) a robe ...UNK (unknown) places [s/he] likes to go ..." Resident 2 was found in the driveway by police. 06/14/2026 at 5:41 PM: Resident 2 and Resident 3 left the home located by police "[Resident 2] and [Resident 3] both eloped ...both left opposite directions ...HO [home owner] ...Partridge Ct advising they are out with [Resident 2] in the backyard ...[Resident 2] and [Resident 3] were both located and returned to the group home ...[Caregiver B] was on scene to take custody of both subjects." 06/15/2026 at 3:15 AM: Resident 2 eloped to neighbor's house "Someone ringing doorbell. Barefoot [gender] ...states the [gender] is saying that [s/he's] lost	M 230			

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M 230	Continued From page 25 ...POI (Person of Interest) has been at the front door for 5 mins (minutes). Is still ringing doorbell ...POI is looking into the house ...[S/he] was given a ride back to the home and staff member informed about the incident ..." 06/17/2026 at 4:07 PM: Resident 2 eloped to dentist's office "[Resident 2] is on scene, ran away from group home ...sitting in lobby. Said someone was trying to attack [him/her] ...assisted [Resident 2] with getting into the house ..." All six police reports reflected they located Resident 2 with no caregiver present and returned Resident 2 to his/her home. Behavior Support Plan On 07/08/2026, Surveyor reviewed Resident 2's behavior support plan dated 06/05/2025. The BSP noted the following: Behaviors: Verbal aggression, self-injurious behavior, property destruction and elopements. The BSP had specific instructions should Resident 2 elope as follows: -elopement bag should be by the front exit and contain water, snacks, hand pads for blocking, flashlight and facesheet. -Upon elopement, staff should grab the bag, follow him/her and always maintain line of sight. Individual Support Plan 12/10/2025 On 07/08/2026, Surveyor reviewed Resident 2's ISP dated 12/10/2025. The ISP noted Resident 2 was protectively placed and had a legal guardian. The ISP specified the following: Level of Supervision: 1:1 dedicated staffing 24/7 Behaviors: Aggressive behaviors, self-injurious	M 230		

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M 230	Continued From page 26 behaviors, sexually motivated behaviors, property destruction and elopement attempts. Resident 2 required a 1:1 level of supervision. According to Resident 2's BSP, upon elopement, caregivers were to follow Resident 2 and keep him/her within line of sight. Review of the police reports showed the police located Resident 2 with no caregivers present. There was no evidence to show Resident 2 was provided the 1:1 level of supervision when s/he eloped. RESIDENT 3 Interview with Licensee A On 07/13/2026 at 8:45 AM, Surveyors interviewed Licensee A regarding Resident 3. Licensee A stated Resident 3 resided at his/her West Bend location. Licensee A stated Resident 3 does not come to this house. Surveyors shared the police report from 05/23/2026 and 06/14/2026 when Resident 2, who requires a 1:1 level of supervision eloped. Surveyors discussed the police report noted the only caregiver at the home was Caregiver B. Licensee A stated staffing schedules are on his/her computer, and s/he would need to send them. Surveyor Note: the staffing schedules were not sent prior to the exit. Police Report On 07/13/2026, Surveyor reviewed police dated 06/14/2026 at 5:41 PM. The police report documented the following: "[Resident 2] and [Resident 3] both eloped ...both left opposite directions ...HO [homeowner] ...Partridge Ct advising they are out with [Resident 2] in the backyard ...[Resident 2] and	M 230		

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M 230	Continued From page 27 [Resident 3] were both located and returned to the group home ...[Caregiver B] was on scene to take custody of both subjects." Surveyor reviewed police dated 05/23/2026 at 5:42 PM. The police report documented the following: "Staff advising a client eloped - RP cant go after them since there is no other staff member on scene" "RP states when [s/he] is located, please bring [him/her] back and have RP come outside to talk to them rather than having officers go inside the residence" Individual Support Plan On 07/13/2026, Surveyors reviewed Resident 3's ISP. The ISP noted Resident 3 is diagnosed with traumatic brain injury, bipolar disorder, depression, schizophrenia and Anxiety. The ISP noted Resident 3 requires 1:4 dedicated staffing. The ISP further noted Resident 3 was admitted due to behavioral concerns. Assessment On 07/13/2026, Surveyor reviewed Resident 3's assessment dated 03/25/2026. The assessment noted Resident 3 required 24-hour direct supervision. Resident 3 did not reside at the 6935 Pioneer Rd. location but was there on 06/14/2026. Resident 2 and Resident 3 eloped and were later found by the police department and returned home. Resident 2 required a 1:1 level of supervision and Resident 3 required 24-hour direct supervision. The licensee did not provide schedules to verify staffing levels were maintained. Cross Reference M0134 DHS 88.03(5)(e)(1)	M 230		

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M 230	Continued From page 28 Significant Change To The Resident Cross Reference M0216 DHS 88.04(2)(a) Responsibilities Cross Reference M0218 DHS 88.04(2)(b) Awake Staff for Continuous Care Cross Reference M0424 DHS 88.06(3)(f) Review of ISP Cross Reference M0582 88.10(3)(q) Medications	M 230		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the adult family home was well-maintained and provided a homelike environment for 1 of 1 resident. Findings include: On 07/13/2026 at 8:05 AM, Surveyors entered with Licensee A. Surveyors observed garage windows covered with wood and all windows in the house covered with fabric. Surveyors observed the refrigerator splattered with food-like substances and splatters of red food-like substance on the walls and ceiling. At approximately 8:30 AM, Surveyors observed black mold like substance on the wall in the	M 276		

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M 276	Continued From page 29 basement laundry area and dryer vent area to be covered with lint-like substance. Surveyors observed the hallway floor by the back door to be sticky. On 07/13/2026 at 8:30 AM, Licensee A acknowledged the wood covering the garage windows and stated the landlord must have placed the wood over the windows. Licensee A stated s/he had told staff to clean the basement this past weekend and was surprised staff had not cleaned. Licensee A stated s/he would look at the concerns identified. On 07/13/2026 at 12:51 PM, Surveyors interviewed Landlord E. Landlord E stated s/he had not been at this house and had not placed wood over the windows. Landlord E stated if the windows were covered Licensee A must have had someone cover. The provider did not ensure the adult family home was well-maintained and provided a clean homelike environment for 1 of 1 resident. Cross Reference M0216 DHS 88.04(2)(a) Responsibilities	M 276		
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	M 424		

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M 424	Continued From page 30 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 ensure the individual service plan (ISP) was updated whenever the residents' needs changed for Resident 1 and Resident 2. Resident 1's ISP was not updated to reflect a change in the level of supervision needed. Resident 2's ISP was not updated to reflect elopement interventions. Resident 2 eloped from the facility 6 times. Findings Include: On 05/21/2026 and 06/17/2026, the department received complaints concerning supervision of residents. RESIDENT 1 Assessment ON 07/13/2026, Surveyor reviewed Resident 1's assessment dated 04/08/2024. The assessment identified Resident 1 required "24-hour direct	M 424		

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M 424	Continued From page 31 supervision." Member Centered Plan 05/17/2025 On 07/13/2026, Surveyor reviewed Resident 1's managed care organizations member centered plan (MCP), dated 05/17/2025. The MCP noted Resident 1 required "1:1 staff 24 hours a day" and "line of sight only when potentially hazardous items are being utilized." Member Centered Plan 06/01/2026 On 07/13/2026, Surveyor reviewed Resident 1's most current MCP dated 06/01/2026. The MCP noted Resident 1 required "24/7 care and supervision ...overnight care/supervision ..." Individual Support Plan 04/07/2025 On 07/13/2026, Surveyor reviewed Resident 1's ISP dated 04/07/2025. The ISP specified Resident 1 had a corporate guardian and required "1:1 supervision as needed upon behaviors ..." Individual Support Plan 05/08/2025 On 07/13/2026, Surveyor reviewed Resident 1's most current ISP dated 05/08/2025. The ISP noted Resident 1 was protectively placed. The ISP did not include information to identify the level of supervision Resident 1 required. Additionally, there was no documentation in the record the ISP was reviewed every 6 months. On 07/13/2026, at 8:05 AM, Surveyors interviewed Licensee A regarding Resident 1's level of supervision. Licensee A stated Resident 1 no longer requires 1:1 supervision and s/he can leave the home unsupervised for short distances and go to work. Licensee A acknowledged level of supervision should be updated and documented in the ISP.	M 424			

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M 424	Continued From page 32 On 07/15/2026, at 10:35 AM, Surveyors interviewed Guardian F. Guardian F identified s/he has been Resident 1's corporate guardian for approximately 2 years and confirmed s/he is protectively placed. Guardian F reported Resident 1 should have awake staff overnight and should not leave the home unsupervised unless it is to go to work at Piggly Wiggly. Review of Resident 1's MCPs and ISPs showed Resident 1's level of supervision changed, and s/he no longer required a 1:1 level of supervision but still required 24-hour supervision. According to Licensee A, Resident 1 could leave the home unsupervised. The most recent ISP dated 05/08/2025 did not include any information about Resident 1's level of supervision. Additionally, the ISP was not reviewed every 6 months. RESIDENT 2 Behavior Support Plan On 07/08/2026, Surveyor reviewed Resident 2's behavior support plan dated 06/05/2025. The BSP noted the following: Behaviors: Verbal aggression, self-injurious behavior, property destruction and elopements. The BSP had specific instructions should Resident 2 elope as follows: -elopement bag should be by the front exit and contain water, snacks, hand pads for blocking, flashlight and facesheet. -Upon elopement, staff should grab the bag, follow him/her and always maintain line of sight. Individual Support Plan 12/10/2025 On 07/08/2026, Surveyor reviewed Resident 2's ISP dated 12/10/2025. The ISP noted Resident 2	M 424		

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M 424	Continued From page 33 was protectively placed and had a legal guardian. The ISP specified the following: Level of Supervision: 1:1 dedicated staffing 24/7 Behaviors: Aggressive behaviors, self-injurious behaviors, sexually motivated behaviors, property destruction and elopement attempts. Eloperments On 07/08/2026, Surveyor reviewed police reports. The reports showed Resident 2 eloped from the home 6 times. 04/13/2026 at 3:38 PM: Resident 2 eloped to a dentist's office 05/31/2026 at 3:39 PM: Resident 2 eloped to a neighbor's house 06/06/2026 at 12:38 AM: Resident 2 ran out and whereabouts were unknown 06/14/2026 at 5:41 PM: Resident 2 and Resident 3 left the home located by police 06/15/2026 at 3:15 AM: Resident 2 eloped to neighbor's house 06/17/2026 at 4:07 PM: Resident 2 eloped to dentist's office Review of the police reports showed police responded to each location and there were no caregivers present with Resident 2. Each elopement resulted with the police returning Resident 2 to the home. On 07/08/2026, at 8:45 AM, Surveyors interviewed Licensee A. Licensee A advised Resident 2 discharged from the home on	M 424		

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M 424	Continued From page 34 07/01/2026. Licensee A confirmed Resident 2 had elopements that mostly occurred in the afternoon. Licensee A confirmed Resident 2 had a BSP and required a 1:1 level of supervision. Licensee A acknowledged supervision interventions should be updated in the ISP. Resident 2's BSP identified when s/he elopes from the home, caregivers should grab the elopement bag and follow him/her. Resident 2's ISP was not updated to reflect interventions for elopements noted in the BSP. Subsequently, Resident 2 eloped 6 times requiring police intervention. Cross Reference M0134 DHS 88.03(5)(e)(1) Significant Change To The Resident Cross Reference M0216 DHS 88.04(2)(a) Responsibilities Cross Reference M0218 DHS 88.04(2)(b) Awake Staff for Continuous Care Cross Reference M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm	M 424		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe	M 550		

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M 550	Continued From page 35 that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 residents had privacy in their own home. Findings Include: The facility is licensed to provide care for up to 4 residents who may be emotionally disturbed/mental illness, physically disabled, pregnant women/counseling, advanced age, developmentally disabled, alcohol/drug dependent, traumatic brain injury, correctional clients, terminally ill and/or irreversible dementia/Alzheimer's. On 07/13/2026 at 7:20 AM, Surveyors interviewed Caregiver C. Caregiver C confirmed Person G stays at this home on the weekends, and staff drops him/her off during the week when there are no caregivers at the other house. Caregiver C confirmed Resident 2 and Person G had both eloped from the facility and the police were called. On 07/13/2026 at 8:10 AM, Surveyors entered the home and interviewed Licensee A. Licensee A stated Person G did not reside at this location and was not at this house. Licensee A stated the only time Person G would be at this location is if Person G was with Licensee A and s/he needed to stop at the house. Licensee A stated Person G was never at this location without him/her. Surveyors shared police reports identifying Person G eloping from this location with no staff present. Licensee A stated s/he was unaware of these incidents.	M 550		

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M 550	Continued From page 36 The provider did not ensure 2 of 2 residents had privacy in their own home.	M 550			
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review, interview and observation, the provider did not ensure residents received medications as they were prescribed for Resident 1. Resident 1 was protectively placed and had a corporate guardian. Resident 1 stayed overnight at a family member's house and the Licensee did not ensure Resident 1 had his/her medications. Findings Include: Interview with Licensee A On 07/13/2026 at 8:05 AM, Surveyors entered the home to conduct three complaint investigations. Licensee A advised Resident 1 was out with family. Licensee A reported Resident 1 went with his/her family member yesterday (07/12/2026).	M 582			

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M 582	Continued From page 37 Licensee A explained Resident 1 did not return home because s/he wanted to spend the night with the family member. Licensee A confirmed Resident 1 did not take any of his/her medications and missed his/her evening medications for 07/12/2026 and morning medications for 07/13/2026. Member Centered Plan On 07/13/2026, Surveyor reviewed Resident 1's most current MCP dated 06/01/2026. The MCP noted the following: Resident 1 required "full assist" medication administration due to cognition. Individual Support Plan On 07/13/2026, Surveyors reviewed Resident 1's individual support plan (ISP), dated 05/08/2025. The ISP noted Resident 1 had the following diagnosis: borderline intellectual functioning, anxiety disorder, post-traumatic stress disorder, impulse disorder, disruptive mood disorder, reactive attachment disorder of childhood, psychotic disorder with delusions due to known physiological, attention-deficit hyperactivity disorder and schizoaffective disorder. The ISP identified Resident 1 required assistance with medication administration. Observation On 07/13/2026, at approximately 8:45 AM, Surveyors observed Resident 1's medications were in the locked medication drawer. Observation of the medications confirmed the pills for the evening of 07/12/2026 and the morning of 07/13/2026 were still in the bubble pack. Medications observed still in the bubble pack were as follows: 07/13/2026 Morning/AM dose observed in bubble	M 582			

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M 582	Continued From page 38 pack Multi-vit/min (certavite) - take 1 tablet twice daily Bupropion XL 300mg - take 1 tab daily for depression Topiramate 50mg - take 1 tab twice daily Aspirin 81mg CHW - chew and swallow 1 tab daily Levothyroxine 25mcg - take 1 tab daily for hypothyroid Lamotrigine 150mg - take 1 tab twice daily (morning and evening) for seizures VIT D2 50,000U - take 1 cap by mouth one time weekly 07/12/2026 Evening/PM dose observed in bubble pack Multi-vit/min (certavite) - take 1 tablet twice daily Clonidine 0.1mg - take 1 tab by mouth every evening for anxiety Trazodone 100mg - take 1 tab once daily at bedtime Cyclobenzaprine 5mg - take 1 tab at bedtime Quetiapine 100mg - take 1 tab daily at bedtime Gabapentin 300mg - take 1 cap daily at bedtime Lamotrigine 150mg - take 1 tab twice daily (morning and evening) for seizures Topiramate 50mg - take 1 tab twice daily Surveyor Note: The July 2026 MAR was not present for review. Interview with Guardian F On 07/15/2026, at 10:35 AM, Surveyors interviewed Guardian F. Guardian F identified s/he has been Resident 1's corporate guardian for approximately 2 years and confirmed s/he is protectively placed. Guardian F advised s/he was unaware Resident 1 had an unsupervised overnight visit at a family's members home. Guardian F reported this needed discussion and	M 582		

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M 582	Continued From page 39 approval prior to occurring. Guardian F described the importance of Resident 1 to take his/her medications as s/he just got out of treatment on 06/22/2026 for suicidal ideations. Cross Reference M0216 DHS 88.04(2)(a) Responsibilities Cross Reference M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm	M 582		
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.	Z 023		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/15/2026
NAME OF PROVIDER OR SUPPLIER COMPASSIONATE ADULT FAMILY HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6935 W PIONEER RD MEQUON, WI 53097		
(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 40 This Rule is not met as evidenced by: Based on record review and interview, the facility permitted Caregiver B to work in the home when Caregiver B had a barred offense. - Caregiver B was charged with aggravated battery 940.19(6) Findings include: On 07/13/2026 at 8:15 AM, Surveyors requested a staff roster from Licensee A. Licensee A stated s/he had left all staff go and that s/he was the only one working. Surveyors asked Licensee A when Caregiver B had started employment and when s/he left and requested Caregiver B's record. Caregiver B's record identified the following: -Caregiver B had a hire date of 04/27/2026 -Caregiver B's Department of Justice, dated 04/27/2026, noted that Caregiver B was charged with aggravated battery 940.19(6), on 12/06/2018 (the county case document showed Caregiver B was guilty of Felony H 940.19(6)) On 07/13/2026 at 11:45 AM, Surveyors interviewed Caregiver B. Caregiver B was currently working at the sister facility. Caregiver B stated s/he started at the Mequon location, but when the census was low, Licensee A moved him/her to the West Bend location. Caregiver B confirmed s/he works full-time between the 2 houses. Caregiver B acknowledged the aggravated battery happened years ago.	Z 023		

Wisconsin Department of Health Services

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NAME OF PROVIDER OR SUPPLIER COMPASSIONATE ADULT FAMILY HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6935 W PIONEER RD MEQUON, WI 53097		
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Z 023	Continued From page 41 On 07/13/2026 at 12:00 PM, Surveyors interviewed Licensee A. Licensee A acknowledged s/he does not always look at caregivers' background. Licensee A stated s/he was unaware Caregiver B couldn't work with this charge. Surveyors shared the list of barred offenses and that Caregiver B could not be in the home with residents. Licensee A stated s/he would work on a replacement for Caregiver B. The facility permitted Caregiver B to work in the home when Caregiver B had a barred offense. Cross Reference M0216 DHS 88.04(2)(a) Responsibilities Cross Reference M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm	Z 023		