STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAYS SAFE HAVEN	12835 WEST LANCASTER AVENUE BUTLER, WI 53007

(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 07/21/2026, Surveyor conducted a standard survey. Six deficiencies were identified. Two of 6 deficiencies were repeat violations. See Statement Of Deficiency U5EV11 dated 11/22/2023. Census: 4	M 000		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation was obtained from a physician, a registered nurse or a physician's assistant indicating each service provider has been screened for communicable disease including tuberculosis (TB) within 90 days prior to start of providing service. Caregiver G was not screened for TB within 90	M 232		

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

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M 232	Continued From page 1 days prior to start of providing service. Findings include: The adult family home is licensed to serve up to 4 residents within the client groups of alcohol/drug dependent, correctional clients, traumatic brain injury, emotionally disturbed/mental illness, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, terminally ill, and advanced age. On 07/22/2026 at 11:37 AM, Surveyor received Caregiver G's employee file via email from Licensee A. S/he was hired 12/07/2025. The file contained a TB test completed 08/08/2023, 852 days prior to hire date. On 07/22/2026 11:37 AM, Surveyor received an email from Licensee A containing a "Staff Health Report" dated 07/14/2025. The report identified Caregiver G was at low risk for TB and TB test results were negative, but the TB test date box was blank. On 07/22/2026 at 2:04 PM, Surveyor discussed concern of Caregiver G's TB test was completed too early with Licensee A who stated s/he was not sure why the TB test was completed too early or where the 2025 TB test information originated from since it did not identify date of a TB test.	M 232		
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	M 336		

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M 336	Continued From page 2	M 336		

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 each smoke detector was tested monthly.
In 2024 and 2025, smoke detectors were tested every other month.

Findings include:

The adult family home is licensed to serve up to 4 residents within the client groups of alcohol/drug dependent, correctional clients, traumatic brain injury, emotionally disturbed/mental illness, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, terminally ill, and advanced age.

On 07/21/2026, Surveyor reviewed the 2024 monthly smoke detector testing documentation dated 01/19/2024, 03/20/2024, 05/17/2024, 07/16/2024, 09/15/2024 and 11/15/2024.

On 07/21/2026 at 1:28 PM, Surveyor discussed concern of smoke detector testing completed only every other month with Licensee A and Director of Operations B. Licensee A stated s/he would send Surveyor the 2025 smoke detector tests. Surveyor reviewed DHS ch. 88.05(4)(b)2 with them and Licensee A stated, "Okay."

On 07/21/2026 at 6:02 PM, Surveyor received an email from Licensee A with an attachment of 2025 smoke detector tests dated 01/2025,

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M 336	Continued From page 3 03/10/2025, 05/17/2025, 07/19/2025, 09/22/2025, and 11/20/2025. Cross Reference: M0570 88.10(3)(I) Safe Physical Environment	M 336		
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 observation, record review and interview, the provider did not ensure the individual service plan was updated when there was a change in resident's needs. Resident 4's assessment did not include description of medical symptom or condition	M 424		

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warranting use of side rail, alternative interventions to side rail tried and reason(s) why alternative interventions were not successful. Resident 4's individual service plan (ISP) did not identify need for side rail or when side rail should be in up position, describe trials of less restrictive interventions, include education provided to resident and/or resident's legal representative regarding risks of side rail use or plans to reduce side rail use and monitor bed, mattress and side rails for safety.

This is a repeat violation. See Statement Of Deficiency U5EV11 dated 11/22/2023.

Findings include:

According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment. 2. Because individuals may differ in their sleeping and night-time habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and

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determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach... Bed Rail Safety Guidelines If it is determined that bed rails are required and that other environmental or treatment considerations may not meet the individual patient's assessed needs, or have been tried and were unsuccessful in meeting the patient's assessed needs, then close attention must be given to the design of the rails and the relationship between rails and other parts of the bed. 1. The bars within the bed rails should be closely spaced to prevent a patient's head from passing through the openings and becoming entrapped. 2. The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering. 3. Care should be taken that the mattress does not shrink over time or after cleaning. Such shrinkage increases the potential space between the rails and the mattress. 4.

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Check for compression of the mattress' outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail. 5. Ensure that the mattress is appropriately sized for the selected bed frame, as not all beds and mattresses are interchangeable. 6. The space between the bed rails and the mattress and the headboard and the mattress should be filled either by an added firm inlay or a mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails. 7. Latches securing bed rails should be stable so that the bed rails will not fall when shaken. 8. Older bed rail designs that have tapered or winged ends are not appropriate for use with patients assessed to be at risk for entrapment. Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings 11 9. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items (See Appendix 1: Glossary) should be ongoing. " (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 07/22/2026)).

On 07/21/2026 at 12:56 PM while touring facility with Licensee A and Director of Operations B, Surveyor observed a 1/2 side rail in the up position attached to the room side of Resident 4's bed (photo 6). Surveyor measured approximately 6 inches of gap between the mattress and the siderail and when Surveyor grasped the top of the siderail to test its stability, there was approximately 2" of sway.

On 07/21/2026 at 12:56 PM, Surveyor

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interviewed Licensee A who stated Resident 4's managed care organization (MCO) ordered the bed, and upon delivery, the side rail was attached to it. Licensee A stated Resident 4 was able to transfer him/herself in and out of bed independently.

On 07/21/2026, Surveyor reviewed Resident 4's record. S/he was admitted 06/09/2025.
The record contained an assessment dated 05/29/2025 which identified s/he was independent with transfers and ambulation with a walker. The assessment did not include bed mobility, and the record did not contain a separate assessment for bed mobility/repositioning or siderail use.

Resident 4's ISP was dated 12/12/2025 and identified s/he required monitoring/assistance with transferring and mobility and utilized a wheeled walker. The ISP did not identify need for assistance with bed mobility/repositioning or identify use of/need for side rail.

MCO Member Care Plan dated 07/01/2026-12/31/2026 (received from Licensee A via email 07/21/2026 at 6:02 PM) stated:
In the area of Other Supports " ...Monitor for safety and effectiveness of [durable medical equipment] ..."
The MCO Member Care Plan did not identify need for assistance with bed mobility/repositioning or use of/need for side rail.

On 07/21/2026 at 1:28 PM, Surveyor discussed concern of no assessment of bed mobility/repositioning or Resident 4's side rail and ISP was not updated to identify use of side rail with Licensee A and Director of Operations B. Licensee A stated prior to delivery of current bed in early September 2025, Resident 4 had a

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M 424	Continued From page 8 smaller bed with no side rail(s), but because s/he needed a bariatric bed, the MCO delivered the current bed with the side rail attached to it. Licensee A stated they did not assess bed mobility/repositioning and/or need for the side rail because they trusted the MCO. Licensee A stated Resident 4 used the side rail for repositioning in bed. Licensee A acknowledged risk of injury with side rails and stated they would assess Resident 4's bed mobility and repositioning and discuss with the MCO replacing the side rail with a repositioning bar.	M 424		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment. The dryer's vent was not made of rigid vent material and was greater than 8 feet in length. This is a repeat violation. See Statement Of Deficiency U5EV11 dated 11/22/2023.	M 570		

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M 570	Continued From page 9 Findings include: The adult family home is licensed to serve up to 4 residents within the client groups of alcohol/drug dependent, correctional clients, traumatic brain injury, emotionally disturbed/mental illness, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, terminally ill, and advanced age. According to the US Fire Administration, " ...2,900 home clothes dryer fires are reported each year and cause an estimated 5 deaths, 100 injuries, and $35 million in property loss ...Maintenance Inspect the venting system behind the dryer to ensure it is not damaged or restricted. Put a covering on outside wall dampers to keep out rain, snow and dirt. Make sure the outdoor vent covering opens when the dryer is on. Replace coiled-wire foil or plastic venting with rigid, non-ribbed metal duct ..."(Source: https://www.usfa.fema.gov/prevention/outreach/clothes_dryers.html (retrieval date 07/22/2026)). On 07/21/2026 at 1:15 PM while touring the home with Director of Operations B, Surveyor observed the dryer vent. The vent was made of flexible material and the length of the vent was greater than 8 feet (Photos 7 and 8). On 07/21/2026 at 1:15 PM, Surveyor interviewed Director of Operations B who stated s/he had not realized the dryer vent was flexible and that s/he agreed with Surveyor the length of the vent was greater than 8 feet. Director of Operations B stated previously the dryer vent tube was made of rigid material but a couple of months ago the vent was replaced. Surveyor explained the flexible duct must meet the UL 2158A listing requirements and be approved for use by the	M 570		

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M 570	Continued From page 10 dryers manufacturer and cannot be more than 8 feet long. On 07/21/2026 at 1:28 PM, Surveyor discussed concern of dryer vented with flexible venting material with Licensee A and Director of Operations B. Licensee A stated the dryer vent was replaced after the basement flooded in August 2025 and they would replace it with a shorter rigid vent. On 07/22/2026 at 1:32 PM, Surveyor received an email from Licensee A with an attached photo of the dryer with a rigid vent. Cross Reference: M0334 88.05(4)(b)2 Smoke Detectors-Testing And Maintenance	M 570		
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 observation, record review, and interview the provider did not ensure residents received all prescribed medications in the	M 582		

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M 582	Continued From page 11	M 582		

dosages and intervals as prescribed by the physician.

Four of 4 residents reviewed had not received all medications as ordered by their physicians.

Findings include:
The adult family home is licensed to serve up to 4 residents within the client groups of alcohol/drug dependent, correctional clients, traumatic brain injury, emotionally disturbed/mental illness, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, terminally ill, and advanced age. Census on 07/21/2026 was 4.

On 07/21/2026 at 11:34 AM Surveyor inspected the medication cart with Licensee A and Director of Operations B. On 07/21/2026, Surveyor reviewed Resident 1's, Resident 2's, Resident 3's, and Resident 4's records.

Example 1- Resident 1
The medication cart contained 1 bottle of polyethylene glycol 3350 for Resident 1.
Pharmacy label identified (Photo 1):
Poly glycol 3350 powder mix 17 grams with 4 oz. to 8 oz. liquid and giver per g-tube once daily.
Dispensed: 11/19/2024
Quantity: 510 grams (Note: 30 doses)
Director of Operations B stated the bottle was approximately 1/8 full.

Resident 1 was admitted 11/15/2021. Physician orders included poly glycol 3350 powder mix 17 grams with 4 oz. to 8 oz. of liquid and give per g-tube once daily (start date 11/19/2024).

Medication administration record (MAR):
From 01/05/2026 to 07/20/2026, staff documented administration of 201 doses of poly

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glycol to Resident 1.

Individual Service Plan (ISP) dated 01/17/2026
In the area of Medication Management "
...requires medication administration by the AFH provider ...Administration means the AFH provider is responsible for removing the proper dosage from the labeled prescription bottle and giving it to the member ..."

Example 2- Resident 2
The medication cart contained 1 bottle of polyethylene glycol 3350 for Resident 2.
Pharmacy label identified (Photo 2): 11:55 AM
Polyglycol 3350 powder 510 grams mix 17 grams in 4-8 oz of liquid, stir well and drink once daily.
Dispensed 11/18/2025
Quantity 510 grams (Note: 30 doses)
Director of Operations B stated the bottle was approximately ½ full.

Resident 2 was admitted 01/21/2022.
Physician orders included poly glycol 3350 powder mix 17 grams in 4-8 ouncers of liquid, stir well and drink once daily (start date 11/18/2025).

MAR: From 01/05/2026-07/20/2026, staff documented administration of 196 doses of polyethylene glycol 3350 to Resident 2.

ISP dated 01/30/2026:
In the area of Medication Management "
...requires medication administration by the AFH provider ...Administration means the AFH provider is responsible for removing the proper dosage from the labeled prescription bottle and giving it to the member ..."

Example 3- Resident 3
The medication cart contained 1 bottle of Nystatin

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M 582	Continued From page 13 Oral Suspension, USP Pharmacy label identified (Photos 3 and 4): Nystatin 100,000 Units/ML swish in mouth and swallow 5 ML 4 times daily. Dispensed: 10/20/2025 Quantity: 473 ML (Note 23.65 doses) Director of Operations B stated the bottle was almost full. Resident 3 was admitted 10/25/2021. Physician orders included Nystatin 100,000/ML suspension swish and swallow 5 ML by mouth 4 times daily (start 07/28/2025). MAR: From 01/05/2025-07/20/2026, staff documented administration of 707 doses of Nystatin 100,000 ML to Resident 3. Example 4- Resident 4 The medication cart contained 1 bottle of polyethylene glycol 3350 for Resident 4. Pharmacy label identified (Photo 5): Polyethylene glycol 3350 dissolve 17 grams in 8 ounces of water or juice and drink once daily. Dispensed: 12/29/2025 Quantity: 510 grams (Note: 30 doses) Manager B stated the bottle was approximately ¾ full. Resident 4 was admitted 06/09/2025. Physician orders included polyethylene glycol 3350 dissolve 17 grams in 8 ounces of water or juice and drink once daily (start date 12/29/2025). From 02/01/2026-07/20/2026 staff documented administration of 170 doses of polyethylene glycol to Resident 4. ISP dated 07/01/2026: In the area of Medication Management "	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 582	Continued From page 14 ...requires medication administration by the AFH provider ...Administration means the AFH provider is responsible for removing the proper dosage from the labeled prescription bottle and giving it to the member ..." On 07/21/2026 at 11:58 AM, Surveyor interviewed Pharmacy Tech C who stated 1 bottle containing 517 grams of polyethylene glycol was dispensed 11/19/2024 for Resident 1, and the medication was not dispensed since. Pharmacy Tech C stated 1 bottle containing 517 grams of poly glycol was dispensed for Resident 2 on 11/18/2025, and the medication was not dispensed since. Pharmacy Tech C stated Nystatin 100,000 Units/ml 473 grams was dispensed 10/20/2025 and the medication was not dispensed since. On 07/21/2026 at 12:06 PM, Surveyor interviewed Pharmacist D who stated 517 grams of poly glycol was dispensed 12/29/2025 and had not been dispensed since. On 07/21/2026 at 12:12 PM, Surveyor interviewed Licensee A and Director of Operations B who stated staff administer medications to all 4 residents. Licensee A stated staff were probably not administering poly glycol to Resident 2 and Resident 4 because they did not have issues with constipation and staff were incorrectly documenting it. Licensee A stated they would contact the physicians to have the orders changed to as needed and would retrain staff. On 07/21/2026 at 1:28 PM, Surveyor discussed concern of not administering medication as ordered with Licensee A and Director of Operations B. Licensee A stated House Manager E audited the medication carts monthly but	M 582		

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M 582	Continued From page 15 thought the medication's start dates and order renewal dates listed on the MARs were the dates the medications were dispensed from pharmacy. Licensee A stated since inspecting the medication cart with Surveyor on 07/17/2026, s/he arranged for the facility nurse to retrain staff.	M 582		
M 604	88.10(5)(c)4 Information About Advocacy Organization To have available in the home the name, address and phone number of organizations providing advocacy assistance for the type of individual served by the adult family home, and the name, address and phone number of the licensing agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure correct advocacy contact information was contained in the grievance procedure. The grievance procedure did not include contact information for the Ombudsman program, advocacy contact information for residents under age 60, or the Division of Quality Assurance's Southern Regional Office. Findings include: The adult family home is licensed to serve up to 4 residents within the client groups of alcohol/drug dependent, correctional clients, traumatic brain injury, emotionally disturbed/mental illness, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, terminally ill, and advanced age.	M 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018538	A. BUILDING: _____ B. WING _____	07/22/2026

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M 604	Continued From page 16 On 07/21/2026, Surveyor reviewed Resident 4's record. S/he was admitted 06/09/2026. Included in the record was a Resident Handbook. The last page of handbook stated " ...Receipt I have received and read the Resident Handbook provided to me by Shay's Safe Haven, L.L.C., including information on the grievance procedure ..." followed by Resident 4's guardian's signature and dated 06/13/2025. In the section titled "Grievance Procedure", the Resident Handbook stated " ...You may contact your OMBUDSMAN at any time to assist you with the complaint; a poster should be placed in the facility for your convenience and within plan [sic] sight ...6. You have the right to file a grievance with the Division of Community Services - State of Wisconsin, at any time ... 819 North 6th Street - Room 609- B Milwaukee, WI 53203 ..." The grievance procedure did not include: 1. Contact information for the Board of Aging and Long-Term Care's Ombudsman program for residents over age 60 2. Advocacy contact information for residents under age 60. 3. Correct contact information for the Division of Quality Assurance (DQA) Southern Regional Office located at: 201 E. Washington Ave, Room E300 Madison, WI 53703 Phone: 1-608-264-9888 Or the DQA Complaint Line: 1-608-642-6552 On 07/21/2026 at 1:28 PM, Surveyor discussed concern of the grievance procedure's incorrect and missing advocacy information with Licensee	M 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 604	Continued From page 17 A and Director of Operations B. Licensee A stated they would correct the grievance procedure right away.	M 604		