STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 05/05/2026, Surveyor conducted an abbreviated survey and complaint investigation at Above & Beyond AFH III. Five deficiencies were identified. One complaint was substantiated. Census: 4	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 interview and record review, the provider did not report to the Department within 24 hours, when 1 of 1 resident (Resident 1) eloped from the home on 03/09/2026 and was returned to the facility by Racine County Police Department (RC PD). Findings include: Resident 1 was admitted to this facility on 04/03/2015 with diagnoses including mood	M 134		

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
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 134	Continued From page 1	M 134		

disorder, cerebrovascular disease, alcohol abuse and dementia., Resident 1 had an activated healthcare power of attorney (AHCPOA) G. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 1's individual service plan (ISP), dated 11/19/2024, indicated Resident 1 required 24-hour supervision in the home.

Resident 1's incident report, dated 03/09/2026 at 4:00 a.m., was filled out by House Lead (HL) C. S/He wrote that Resident 1 eloped and was returned to the facility by RC PD. HL C wrote, "I did a full body assessment on [him/her] and no bumps, bruises or cuts were found."

On 04/30/2026, at 9:00 a.m., Surveyor reviewed the provider's self-report history. The Department did not receive a self-report for Resident 1 eloping from the home from 03/09/2026.

On 04/30/2026, at 9:30 a.m., Surveyor reviewed documentation from the Division of Quality Assurance- Office of Caregiver Quality Assurance. On 03/18/2026, Administrator B submitted a misconduct incident report (MIR), that summarized Resident 1's elopement incident on 03/09/2026.

On 05/01/2026, RC PD provided department with incident report number 26-011288. The report outlined Police Officer (PO) I being dispatched at 6:07 a.m. on 03/09/2026. PO I documented that Resident 1 had stated s/he worked at the establishment where s/he was found. PO I wrote, "[Resident 1] appeared to be very confused, not understanding what I was saying and was adamant that s/he worked there."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 134	Continued From page 2 On 05/05/2026 at 10:25 a.m., Surveyor interviewed Administrator B regarding self-reports submitted to the department. Administrator B stated that s/he had submitted a misconduct incident report (MIR), that summarized Resident 1's elopement incident on 03/09/2026. Surveyor reviewed the code with Administrator B, who stated, "I did not know that I had to submit it to the Bureau of Assisted Living. I thought that where I was sending it was the right place." Administrator B stated s/he was unaware of the 24-hour reporting requirement.	M 134		
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 obtain documentation indicating staff had been screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 232	Continued From page 3 providing service for 2 of 2 staff reviewed (Caregiver E and Caregiver F). Findings include: On 04/23/2026 at 1:40 p.m., Surveyor reviewed the following staff files: Caregiver E was hired 08/21/2025. Caregiver E started working with the residents in the home on 08/25/2025. Caregiver E was tested for tuberculosis (TB) on 08/29/2025; however, the provider did not obtain documentation from a physician, a registered nurse, or a physician's assistant indicating Caregiver E had been screened for illness detrimental to residents, as required. Caregiver E's record did not contain a screening for communicable disease. Caregiver F was hired 07/01/2025. Caregiver F started working with the residents in the home on 07/02/2025. Caregiver F was tested for tuberculosis (TB), however, the provider did not obtain documentation from a physician, a registered nurse, or a physician's assistant indicating Caregiver F had been screened for illness detrimental to residents, as required. Caregiver F's record did not contain a screening for communicable disease. On 05/05/2026 at 9:25 a.m., Surveyor interviewed Administrator B, who confirmed Caregiver E and Caregiver F did not have their communicable disease screenings completed within 90 days prior to the start of service. Administrator B stated, "I noticed that was an issue. I am working on that to get it corrected."	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 4	M 424		
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 ensure 1 of 1 resident's Individual Service Plans (ISP) were updated when the resident's needs had changed. Resident 1 had two ISPs on file dated 11/19/2024. Resident 1's ISP was not updated following her/his elopement on 03/09/2026. In the early morning of 03/09/2026, Resident 1 eloped and was located by Racine County Police Department (RC-PD) approximately 2.5 miles from the home, using his/her walker. On 03/09/2026 at 6:30 a.m., RC-PD returned Resident 1 to the home. Resident 1 wandered	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 5 away from the home without staff knowledge. Findings include: Resident 1 was admitted to this facility on 04/03/2015 with diagnoses including mood disorder, cerebrovascular disease, alcohol abuse and dementia, Resident 1 had an activated healthcare power of attorney (AHCPOA) G. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 1's individual service plan (ISP), dated 11/19/2024, indicated Resident 1 required 24-hour supervision in the home. Resident 1's ISP on file, dated 11/19/2024, identified the following: Resident 1's ISP should have been reviewed and updated by 11/19/2025. Resident 1's ISP, dated 11/19/2024, included signatures from House Lead (HL) C, Case Manager (CM) J and Nurse Case Manager K and dated 05/05/2025. Resident 1's ISP, dated 11/19/2024, did not include a signature from Resident 1's AHCPOA G. Resident 1's record did not include evidence Resident 1's ISP was reviewed and updated on or after 03/09/2025. Resident 1's ISP did not include updates under elopement. The ISP reported the following: General Questions Supervision: 24-hour supervision.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 6 Capacity for self-direction: Cannot make needs known. Resident 1's ISP form was divided into several categories under the heading, "Cares Provided" including activities of daily living (ADLs), instrumental activities of daily living (IADLs), Medication Administration, Behavior Patterns, Physical Health, Mental Health, Social Participation, and Independent Living Skills. Surveyor noted the following section: Wandering/Elopement- Supervision. (Behavior patterns/Wandering Risk). -Directions: Provide supervision and redirection to avoid and prevent wandering episodes. If wandering occurs, determine follow-up plan. -Schedule: Daily@ 8:00 a.m., 12:00 p.m., 4:00 p.m., 10:00 p.m. -Current Status: To receive full supervision and redirection from staff to avoid and prevent wandering episodes, Resident 1 may become confused at times and may state that s/he has to go to work or due to previous history may say s/he wants to go to the bar, staff redirect client and encourage him/her to do an activity. -Resident's desired goals and outcomes: To maintain low level of wandering episodes. -Service provider responsibilities: Staff On 05/05/2026 at 9:59 a.m., Surveyor interviewed HL C, who stated they did not update Resident 1's ISP with any new interventions after his/her elopement on 03/09/2025. However, they told	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 7 staff to have a closer eye on Resident 1. HL C stated, "[Resident 1's] ISP did not change because s/he's had elopement issues since s/he has lived here. It really is not a new behavior." On 05/05/2026 at 9:25 a.m., Surveyor interviewed Administrator B, who stated when there is new staff working with Resident 1, it can be challenging. Administrator B stated they did not update Resident 1's ISP with any new interventions after Resident 1's elopement on 03/09/2025. Administrator B stated that nothing had changed for his/her care. Cross Reference M0434 DHS 88.07(1)(e) Supervision	M 424		
M 434	88.07(1)(e) Supervision The licensee shall arrange for a service provider to be present in the home when the licensee is gone overnight or when the licensee's absence prevents the resident from receiving the services, training or supervision specified in the resident's individual service plan under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for a caregiver (service provider) to be present in the home when a resident required services or supervision. The licensee shared staff between two provider homes and did not ensure the provider's home was staffed when 1 of 3 residents (Resident 1)	M 434		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 434	Continued From page 8 required 24-hour supervision. Findings include: On 03/31/2026, the department received a complaint alleging a resident eloped from the facility. Definition of "Continuous care" from DHS 88 means "the need for supervision, intervention or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night. Note: Examples of persons who need continuous care are wanderers, persons with irreversible dementia, persons who are self-abusive or who become agitated or emotionally upset and persons whose changing or unstable health condition requires monitoring." On 05/05/2026, between 8:45 a.m., and 1:00 p.m., Surveyor reviewed Resident 1's record. The following was identified: Resident 1 was admitted to this facility on 04/03/2015 with diagnoses including mood disorder, cerebrovascular disease, alcohol abuse and dementia, Resident 1 had an activated healthcare power of attorney (AHCPOA) G. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 1's individual service plan (ISP), dated 11/19/2024, indicated Resident 1 required 24-hour supervision in the home. Surveyor reviewed Resident 1's incident report. The following was identified:	M 434		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 434	Continued From page 9	M 434		

Resident 1's incident report, dated 03/09/2026 at 4:00 a.m., was filled out by House Lead (HL) C. S/He wrote that Resident 1 eloped and was returned to the facility by Racine County Police Department (RC-PD). HL C wrote, "I did a full body assessment on [him/her] and no bumps, bruises or cuts were found."

On 04/30/2026, Surveyor reviewed documentation from the Division of Quality Assurance- Office of Caregiver Quality. On 03/18/2026, Administrator B submitted a misconduct incident report (MIR), that summarized Resident 1's Elopement incident on 03/09/2026. Administrator B wrote, "Caregiver D stated they were using the bathroom when [Resident 1] had eloped the home, [sic] Staff stated that they had just checked on our client before s/he eloped, [sic] Staff stated they were able to get our client back home safe. After doing a full investigation, I later leanred [sic] that the story [Caregiver D] provider [sic] wasn't the full truth of the story. [Resident 1] was placed back home by law enforcement."

On 05/01/2026, Surveyor reviewed an Adult Protective Services (APS) report, dated 03/11/2026. Adult Protective Services investigator (APSI) H wrote, "A call was made at 6:30 AM on 3/9/26 regarding the consumer who was found at Pioneer on DeKoven Ave and Memorial Dr. Consumer reportedly has dementia and was seen using a walker. Police returned consumer back to his AFH Above and Beyond." APSI H interviewed HL C, who stated staff were not to sleep during their shifts. APSI H informed HL C that Caregiver D, who was working the night of Resident 1's elopement, must have been sleeping. Resident 1 was found 2.5 miles from the home, using a walker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 434	Continued From page 10 On 05/01/2026, RC PD provided department with incident report number 26-011288. The report outlined Police Officer (PO) I being dispatched at 6:07 a.m. on 03/09/2026. PO I documented that Resident 1 had stated s/he worked at the establishment where s/he was found. PO I wrote, "[Resident 1] appeared to be very confused, not understanding what I was saying and was adamant that s/he worked there." On 05/05/2026 at 10:45 a.m., Surveyor reviewed Resident 1's Behavioral Support Plan, created by Resident 1's Managed Care Organization (MCO) on 11/2025. The document read, "Description of Challenging or Dangerous "Target' Behaviors. Elopement: Leaving the home or a specific area without notifying staff of intended whereabouts ...Situations/Circumstances When Behaviors are Likely to Occur. The situation is more likely to occur when [Resident 1] has a desire to leave the home, and no one is present at the time to redirect him/her to his/her focus." On 05/05/2026 at 8:40 a.m., Surveyor interviewed Caregiver C who stated Resident 1 will try to leave the home, thinking s/he had to go to work. Caregiver C stated Resident 1 had tried to leave during his/her shift and s/he redirects Resident 1 by telling him/her that it is a holiday or a weekend. Caregiver C stated Resident 1 eloped in March on third shift and Caregiver D was terminated. Caregiver C confirmed Resident 1 was returned home by the RC PD. Caregiver C stated, "I do not know how [Resident 1] could have eloped. His/her walker scrapes so loud across the floor, and s/he bangs it on everything. [Caregiver D] must have really been sleeping." On 05/05/2026 at 9:25 a.m., Surveyor interviewed	M 434		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 434	Continued From page 11 Resident 2 and asked if any third shift staff ever slept when they were working. Resident 2 reported that former Caregiver D used to sleep on the job. On 05/05/2026 at 9:25 a.m., Surveyor interviewed Administrator B, who stated Caregiver D was terminated from employment after the elopement incident. Administrator B stated, "When his/her report was off and we found out the police brought [Resident 1] home and s/he was over 2.0 miles away, that was unacceptable." Cross Reference: M0424 88.06(3)(f) Review of ISP	M 434		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 010	Continued From page 12	Z 010		

(am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure every reasonable effort was made to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction for 2 of 2 caregivers (Caregiver E and Caregiver F).

Findings include:

On 05/05/2026, at approximately 11:00 a.m., Surveyor reviewed caregiver records and identified the following:

Caregiver E

-Caregiver E was hired on 08/21/2025. Caregiver E was still employed as of 05/05/2026.

-Caregiver E's Background Information Disclosure (BID) was completed and signed by him/her on 08/22/2025.

-Caregiver E's Department of Justice (DOJ)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 010	Continued From page 13	Z 010		

record was requested and reported on 08/22/2025 and the following was identified:

- "Date of offense: 01/02/2025...Charge: 940.01(1) - Battery... Sequence number: 03...Charge Severity: Misdemeanor ...Disposition: Charge Issued."

-Caregiver E's Governmental Findings Report (GFR) was requested and reported on 10/05/2025 and the following was identified:

-No findings.
-No denials.
-No rehabilitation review findings.
-No exclusions.
-No professional credential, license or certificate found.

-Caregiver E's record did not include a copy of the criminal complaint, or a judgement of conviction from the clerk of courts for the charge of 940.01(1) - Battery indicated on Caregiver E's background check.

Caregiver F

-Caregiver F's record did not include a copy of the criminal complaint, or a judgement of conviction from the clerk of courts for the charge 947.01(1) - Disorderly Conduct indicated on Caregiver F's background check.

-Caregiver F's Background Information Disclosure (BID) was completed and signed by him/her on 06/30/2025.

-Caregiver F's Department of Justice (DOJ) record was requested and reported on 07/01/2025 and the following was identified:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017610	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND AFH III	5214 16TH ST MOUNT PLEASANT, WI 53406

(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 010	Continued From page 14 - "Date of offense: 04/21/2025...Charge: 947.01(1) - Disorderly Conduct... Sequence number: 01...Charge Severity: Misdemeanor ...Disposition: Convicted." -Caregiver F's GFR was requested and reported on 07/01/2025 and the following was identified: -No findings. -No denials. -No rehabilitation review findings. -No exclusions. -No professional credential, license or certificate found. -Caregiver F's record did not include a copy of the criminal complaint, or a judgement of conviction from the clerk of courts for the charge indicated on Caregiver F's background check. On 05/05/2026, at approximately 11:20 a.m., Surveyor interviewed Administrator B, who stated s/he was unaware of the requirement to include a copy of the criminal complaint, judgement of conviction from the clerk of courts, and any form of documentation of a rehabilitation review for the charge. Administrator B reported s/he did not complete any further investigations.	Z 010		