STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 06/30/2025, Surveyor conducted a verification visit at Aniyahs House. Additional information was gathered through 07/01/2025. As a result of the survey ten (10) deficiencies identified; eight (8) deficiencies are repeat violations and two (2) new deficiencies identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
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: The provider is licensed to provide services for up to 3 residents who may have a developmental disability, traumatic brain injury, Alzheimer's/dementia, emotionally disturbed/mentally illness, correctional clients, terminally ill, and/or be advanced aged. On 06/30/2025, Surveyors conducted a verification visit. The provider was issued a total of 10 deficiencies. Two (2) deficiencies were new, and eight (8) deficiencies were repeat	M 216		

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
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 216	Continued From page 1 violations. 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). N232 DHS 88.04(2)(g)1 Health Screening For Staff (Repeat) Based on record review and interview, Licensee A did not ensure 3 of 3 caregivers (Caregiver B, Caregiver C and Caregiver E) reviewed were screened for illness detrimental to residents, including for tuberculosis (TB) within 90 days before the start of providing care. N244 DHS 88.04(5)(a) Training 15 Hours Within 6 Months (Repeat) Based on record review and interview, the provider did not ensure that 2 of 2 service providers (Caregiver B and Caregiver E) received resident rights training with his/her 15 hours of initial training. N276 DHS 88.05(3)(a) Home Environment Based on observation and interview, the provider did not ensure the adult family home was well-maintained and provide a homelike environment for 3 of 3 residents. N346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation (Repeat) Based on record review and interview, the provider did not ensure 3 of 3 residents were evaluated annually for evacuation time, using the Department's form. N384 DHS 88.06(2)(b) Service Agreement Except Respite (Repeat)	M 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 216	Continued From page 2 Based on record review and interview, the provider did not have a service agreement for 3 of 3 residents (Resident 1, Resident 2 and Resident 4) prior to admission. N404 DHS 88.06(3)(a) Individual Service Plan & Assessment (Repeat) Based on record review and interview, the licensee did not ensure 3 of 3 residents (Resident 1, Resident 2 and Resident 4's) records had a written assessment and individual service plan (ISP) completed and developed within 30 days after placement. N446 DHS 88.07(2)(b)4 Record of Medical Visits And Reports (Repeat) Based on record review and interview, Licensee A did not ensure record was kept of all medical visits, reports and recommendations for 3 of 3 residents requested. N482 DHS 88.09(1)(a) Resident Records (Repeat) Based on observation, record review and interview, the provider did not maintain records for 3 of 3 residents (Resident 1, Resident 2 and Resident 4) in a secure location within the home. N556 DHS 88.10(3)(e) Self-Direction (Repeat) Based on observation, record review and interview, the provider did not ensure the right to freedom of choice for 2 of 2 residents in the home.	M 216		
{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	{M 232}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 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, Licensee A did not ensure 3 of 3 caregivers (Caregiver B, Caregiver C and Caregiver E) reviewed were screened for illness detrimental to residents, including for tuberculosis (TB) within 90 days before the start of providing care. This is a repeat deficiency. See Statement of Deficiency (SOD) #ELLN11, dated 11/12/2024. Findings include: On 06/30/2025 at 2:15 PM, Surveyor requested Caregiver B, Caregiver C and Caregiver E's communicable disease screening and tuberculosis test. Caregiver E stated s/he did not have access to the records and Surveyor needed to wait for Licensee A. On 06/30/2025 at 2:23 PM, Surveyor talked with Licensee A on the phone. Surveyor stated a verification visit was being conducted and informed Licensee A, Surveyor needed staff records. Licensee A stated s/he would be on his/her way. At 3:50 PM, Licensee A arrived at the adult family home. Licensee A informed	{M 232}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 4 Surveyor s/he had all staff records at his/her office in Milwaukee. Surveyor asked Licensee A how long it would take to go and get the records. Licensee A stated s/he just became aware of the requirements, and s/he was in the process of redoing all staff records. On 06/30/2025, at approximately 4:00 PM, Surveyor reviewed concerns with Licensee A. Licensee A acknowledged s/he was aware of the repeat deficiency. Surveyor informed Licensee A if s/he was able to send any information to Surveyor by noon on 07/01/2025, it would be included in this survey. As of 1:00 PM on 07/01/2025, no additional information was received.	{M 232}		
{M 244}	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 2 service providers (Caregiver B and Caregiver E) received resident rights training with his/her 15 hours of initial training.	{M 244}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 244}	Continued From page 5 This is a repeat deficiency. See Statement of Deficiency (SOD) #ELLN11, dated 11/12/2024. Findings include: The provider is licensed to provide services for up to 3 residents who may have a developmental disability, traumatic brain injury, Alzheimer's/dementia, emotionally disturbed/mentally illness, correctional clients, terminally ill, and/or be advanced aged. On 06/30/2025, Surveyor requested Caregiver B and Caregiver E's record for resident rights training. Caregiver E stated s/he did not have access to the records and Surveyor needed to wait for Licensee A. On 06/30/2025 at 2:23 PM, Surveyor talked with Licensee A on the phone. Surveyor stated a verification visit was being conducted and informed Licensee A, Surveyor needed staff records. Licensee A stated s/he would be on his/her way. At 3:50 PM, Licensee A arrived at the adult family home. Licensee A informed Surveyor s/he had all staff records at his/her office in Milwaukee. Surveyor asked Licensee A how long it would take to go and get the records. Licensee A stated s/he just became aware of the requirements, and s/he was in the process of redoing all staff records. On 06/30/2025, at approximately 4:00 PM, Surveyor reviewed concerns with Licensee A. Licensee A acknowledged s/he was aware of the repeat deficiency. Surveyor informed Licensee A if s/he was able to send any information to Surveyor by noon on 07/01/2025, it would be included in this survey. As of 1:00 PM on 07/01/2025, no additional information was	{M 244}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 244}	Continued From page 6 received.	{M 244}		
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 provide a homelike environment for 3 of 3 residents. Findings include: On 06/30/2025, at approximately 2:30 PM, Surveyor conducted a tour of the home and observed the living carpet with multiple areas of fraying and/or carpet missing. Surveyor observed an area rug in the middle of the living room. On 06/30/2025, at 4:00 PM, Surveyor shared findings with Licensee A. Licensee A stated s/he would reach out to landlord to have the carpet replaced.	M 276		
{M 346}	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using	{M 346}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 346}	Continued From page 7 the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents were evaluated annually for evacuation time, using the Department's form. This is a repeat deficiency. See Statement of Deficiency (SOD) #ELLN11, dated 11/12/2024. Findings include: On 06/30/2025, Surveyor requested Resident 1, Resident 2 and Resident 4's record. Caregiver E stated s/he did not have access to any resident records. Caregiver E acknowledged Licensee A had all resident records at the office in Milwaukee. On 06/30/2025 at 2:23 PM, Surveyor talked with Licensee A on the phone. Surveyor stated a verification visit was being conducted and informed Licensee A, Surveyor needed resident records. Licensee A stated s/he would be on his/her way. At 3:50 PM, Licensee A arrived at the adult family home. Licensee A informed Surveyor s/he had all resident records at his/her office in Milwaukee. Surveyor asked Licensee A how long it would take to go and get the records. Licensee A stated s/he just became aware of the requirements, and s/he was in the process of redoing all resident records. On 06/30/2025, at approximately 4:00 PM,	{M 346}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 346}	Continued From page 8 Surveyor reviewed concerns with Licensee A. Licensee A acknowledged s/he was aware of the repeat deficiencies. Surveyor informed Licensee A if s/he was able to send any information to Surveyor by noon on 07/01/2025, it would be included in this survey. As of 1:00 PM on 07/01/2025, no additional information was received.	{M 346}		
{M 384}	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a service agreement for 3 of 3 residents (Resident 1, Resident 2 and Resident 4) prior to admission. This is a repeat deficiency. See Statement of Deficiency (SOD) #ELLN11, dated 11/12/2024. Findings include: On 06/30/2025, Surveyor requested Resident 1, Resident 2 and Resident 4's record. Caregiver E	{M 384}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 384}	Continued From page 9 stated s/he did not have access to any resident records. Caregiver E acknowledged Licensee A had all resident records at the office in Milwaukee. On 06/30/2025 at 2:23 PM, Surveyor talked with Licensee A on the phone. Surveyor stated a verification visit was being conducted and informed Licensee A, Surveyor needed resident records. Licensee A stated s/he would be on his/her way. At 3:50 PM, Licensee A arrived at the adult family home. Licensee A informed Surveyor s/he had all resident records at his/her office in Milwaukee. Surveyor asked Licensee A how long it would take to go and get the records. Licensee A stated s/he just became aware of the requirements, and s/he was in the process of redoing all resident records. On 06/30/2025, at approximately 4:00 PM, Surveyor reviewed concerns with Licensee A. Licensee A acknowledged s/he was aware of the repeat deficiencies. Surveyor informed Licensee A if s/he was able to send any information to Surveyor by noon on 07/01/2025, it would be included in this survey. As of 1:00 PM on 07/01/2025, no additional information was received.	{M 384}		
{M 404}	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement.	{M 404}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 404}	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure 3 of 3 residents (Resident 1, Resident 2 and Resident 4's) records had a written assessment and individual service plan (ISP) completed and developed within 30 days after placement. This is a repeat deficiency. See Statement of Deficiency (SOD) #ELLN11, dated 11/12/2024. Findings include: On 06/30/2025, Surveyor requested Resident 1, Resident 2 and Resident 4's record. Caregiver E stated s/he did not have access to any resident records. Caregiver E acknowledged Licensee A had all resident records at the office in Milwaukee. On 06/30/2025 at 2:23 PM, Surveyor talked with Licensee A on the phone. Surveyor stated a verification visit was being conducted and informed Licensee A, Surveyor needed resident records. Licensee A stated s/he would be on his/her way. At 3:50 PM, Licensee A arrived at the adult family home. Licensee A informed Surveyor s/he had all resident records at his/her office in Milwaukee. Surveyor asked Licensee A how long it would take to go and get the records. Licensee A stated s/he just became aware of the requirements, and s/he was in the process of redoing all resident records. On 06/30/2025, at approximately 4:00 PM, Surveyor reviewed concerns with Licensee A. Licensee A acknowledged s/he was aware of the repeat deficiencies. Surveyor informed Licensee	{M 404}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 404}	Continued From page 11 A if s/he was able to send any information to Surveyor by noon on 07/01/2025, it would be included in this survey. As of 1:00 PM on 07/01/2025, no additional information was received.	{M 404}		
{M 446}	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure record was kept of all medical visits, reports and recommendations for 3 of 3 residents requested. This is a repeat deficiency. See Statement of Deficiency (SOD) #ELLN11, dated 11/12/2024. Findings include: On 06/30/2025, Surveyor requested Resident 1, Resident 2 and Resident 4's record. Caregiver E stated s/he did not have access to any resident records. Caregiver E acknowledged Licensee A had all resident records at the office in Milwaukee. On 06/30/2025 at 2:23 PM, Surveyor talked with Licensee A on the phone. Surveyor stated a verification visit was being conducted and informed Licensee A, Surveyor needed resident records. Licensee A stated s/he would be on his/her way. At 3:50 PM, Licensee A arrived at the adult family home. Licensee A informed Surveyor s/he had all resident records at his/her	{M 446}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 446}	Continued From page 12 office in Milwaukee. Surveyor asked Licensee A how long it would take to go and get the records. Licensee A stated s/he just became aware of the requirements, and s/he was in the process of redoing all resident records. On 06/30/2025, at approximately 4:00 PM, Surveyor reviewed concerns with Licensee A. Licensee A acknowledged s/he was aware of the repeat deficiencies. Surveyor informed Licensee A if s/he was able to send any information to Surveyor by noon on 07/01/2025, it would be included in this survey. As of 1:00 PM on 07/01/2025, no additional information was received.	{M 446}		
{M 482}	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not maintain records for 3 of 3 residents (Resident 1, Resident 2 and Resident 4) in a secure location within the home. This is a repeat deficiency. See Statement of Deficiency (SOD) #ELLN11, dated 11/12/2024. Findings include: On 06/30/2025, Surveyor requested Resident 1,	{M 482}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 482}	Continued From page 13 Resident 2 and Resident 4's record. Caregiver E stated s/he did not have access to any resident records. Caregiver E acknowledged Licensee A had all resident records at the office in Milwaukee. On 06/30/2025 at 2:23 PM, Surveyor talked with Licensee A on the phone. Surveyor stated a verification visit was being conducted and informed Licensee A, Surveyor needed resident records. Licensee A stated s/he would be on his/her way. At 3:50 PM, Licensee A arrived at the adult family home. Licensee A informed Surveyor s/he had all resident records at his/her office in Milwaukee. Surveyor asked Licensee A how long it would take to go and get the records. Licensee A stated s/he just became aware of the requirements, and s/he was in the process of redoing all resident records. On 06/30/2025, at approximately 4:00 PM, Surveyor reviewed concerns with Licensee A. Licensee A acknowledged s/he was aware of the repeat deficiencies. Surveyor informed Licensee A if s/he was able to send any information to Surveyor by noon on 07/01/2025, it would be included in this survey. As of 1:00 PM on 07/01/2025, no additional information was received.	{M 482}		
{M 556}	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified	{M 556}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 556}	Continued From page 14 in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the right to freedom of choice for 2 of 2 residents in the home. This is a repeat deficiency. See Statement of Deficiency (SOD) #ELLN11, dated 11/12/2024. Findings include: On 06/30/2025, at approximately 2:30 PM, Surveyor toured the home and interviewed residents. On 06/30/2025 at approximately 2:45 PM, Surveyor interviewed Resident 2. Resident 2 stated s/he gets upset with Caregiver E's rules. Resident 2 stated s/he had a car and has a job. Resident 2 stated s/he needs to be in the home by the 9:00 PM curfew, unless s/he would have to work later. Resident 2 stated with fireworks happening after 9:00 PM, s/he did not want to miss them. Resident 2 stated they need to call Licensee A on the phone prior to leaving the house to let him/her know they are leaving, even though there is a caregiver in the house. Resident 2 stated if you are late coming home, Licensee A will talk to you. On 06/30/2025 at approximately 2:45 PM, Surveyor interviewed Resident 4. Resident 4	{M 556}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019051	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIYAHS HOUSE	1063 SUMMER ST WEST BEND, WI 53090

(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 556}	Continued From page 15 stated s/he doesn't like being told s/he cannot sit at the dining room table with his/her roommates. Resident 4 stated if s/he has eaten prior to his/her housemates returning home from work/outing, Caregiver E will not let him/her sit at the table and visit with the other residents. Caregiver E tells Resident 4 it is rude to watch others eat. Resident 4 acknowledged s/he likes to visit with Resident 2 and sometimes s/he gets home after Resident 4 has eaten. Resident 4 stated if s/he sits at the table Resident 2 doesn't need to eat alone. On 06/30/2025 at approximately 3:00 PM, Caregiver E confirmed Resident 2 and Resident 4 have cars and drive. Caregiver E confirmed residents call Licensee A to inform him/her when they are leaving the house. Caregiver E stated Resident 1 has a license, but s/he does not have a car, but rides his/her bike to work or one of the other residents will sometimes give him/her a ride. On 06/30/2025 at approximately 4:00 PM, Surveyor reviewed concerns with Licensee A. Licensee A asked Caregiver E if s/he heard they cannot enforce a curfew. Licensee A expressed concerns with residents not having a curfew.	{M 556}		