STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020036	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEDOM GROUP HOME LLC II	3349 CLOVE DR MADISON, WI 53704

(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 08/18/2026, Surveyor conducted a standard survey and 1 complaint investigation at Freedom Group Home LLC II. Eight deficiencies were identified. The complaint was substantiated. Census: 4	M 000		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure all	M 262		

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

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M 262	Continued From page 1	M 262		

emergency exits from the home were ramped to grade when Resident 1 was unable to walk without the use of a crutch.

Findings include:

The facility is licensed as a nonambulatory adult family home able to serve up to 4 residents within the client groups of physically disabled, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness and advanced age.

On 08/18/2026 at 8:48 AM, Surveyor interviewed Licensee A who stated Resident 1 used a crutch for ambulation since admission due to amputation.

On 08/18/2026, Surveyor reviewed Resident 1's record. S/he was admitted 05/16/2024. Diagnoses included left above knee amputation.

On 08/18/2026 at 12:58 PM, while touring home with Licensee A, Surveyor observed the home's 3 main floor exits:
-Front door was ramped to grade with a wheelchair ramp.
-Side door from kitchen- 1 step down from kitchen floor onto a landing, landing led to a side door to back deck on left, and basement steps on right.
-Garage door from kitchen led onto top of wheelchair ramp into garage. The wheelchair ramp sloped to a landing, on right side of landing was a utility door leading to the back deck and on left side of landing the ramp continued to garage floor. The only 2 exits from the garage were the utility door (leading to the back deck) and an overhead electric garage door.
The only exit off the back deck was 2 steps to

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M 262	Continued From page 2	M 262		

ground (Photo 14).

On 08/18/2026 at 1:01 PM, Surveyor reviewed the emergency exit diagram with Licensee A. The diagram identified the 3 doors on main level as emergency exits. (Note: A door in the basement led outside and was identified as an emergency exit).

On 08/18/2026 at 1:05 PM, Surveyor interviewed Licensee A who stated the overhead garage door was an emergency exit and would be easy to open during a fire even if the electricity was out.

On 08/18/2026 at approximately 1:45 PM, Surveyor discussed concern regarding lack of 2 ramped to grade emergency exits for Resident 1 with Licensee A. Surveyor reviewed the "ADULT FAMILY HOME (AFH) APPLICANT COMPLIANCE STATEMENT" (signed and dated 04/12/2024 by Licensee A), with Licensee A stating " ...I will admit residents that are not able to walk at all; able to walk only with difficulty or only with the assistance of crutches, a cane, or walker; or unable to easily negotiate stairs without assistance; therefore, the facility meets all the following requirements: ...There are at least two exits from the home that are ramped to grade with a hard surfaced pathway and handrails ...Overhead garage doors may not be used as exit doors to the outside ..." Licensee A stated s/he could add another utility door in the garage at bottom of wheelchair ramp or ask Resident 1 if s/he would prefer to move to 1 of Licensee A's other homes.

Cross Reference:
M0332 DHS 88.05(4)(a) Fire Safety-Fire Extinguishers
M0334 DHS 88.05(4)(b)1 Fire Safety-Smoke

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M 262	Continued From page 3 Detectors M0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing And Maintenance M0346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation	M 262		
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 safe, clean, well maintained and provided a home like environment. Findings include: The facility is licensed as a nonambulatory adult family home able to serve up to 4 residents within the client groups of physically disabled, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness and advanced age. On 08/18/2026 at 12:31 PM, Surveyor toured home with Licensee A and observed: Example 1- Main floor bathroom -Wall between sink vanity and toilet soiled with multiple dried amber colored splatters (Photo 1) -2 metal mirror hanger clips attached to wall	M 276		

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M 276	Continued From page 4	M 276		

above mirror and the light fixture below (Photo 2). Licensee A stated the mirror broke and was removed from the clips.
-Multiple horizontal scrapes on lower part of bathroom door, hall side of door (Photo 3)
-Floor vent was rusted (Photo 4)
-Multiple gray and black scuffs and an area of unpainted drywall compound/mud on wall between shower and door (leading to bedroom) (Photo 5).
-Dark black line, approximately 18" long leading from wall onto shower surround.
-Transition from floor into walk-in shower cracked and soiled (Photo 6)

Example 2- Resident 3's room
-Space heater and cell phone charger plugged into 2 prong light duty extension cord (Photo 7). Licensee A stated s/he would purchase Resident 2 a surge protector power strip.
-Dried brown splatters and drips on wall between closet and door (Photo 8). Licensee A stated the splatters and drips were from Resident 3's soda.
-Spider webs in corner (Photo 9)
Licensee A stated Resident 3 did not allow staff to do a lot of things in his/her room.

Example 3- Resident 2's room
Room smelt strongly of urine.
-Outlet cover missing from outlet next to bed (Photo 10).

Example 3- Resident 4's bathroom in basement
-Drawer face missing from 1 vanity drawer (Photo 11)
-Bathtub floor and mat heavily soiled with soap scum (Photo 12)
-Ceiling vent covered with dust and area of unsanded and unpainted drywall compound/mud on ceiling next to veiling vent (Photo 13)

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M 276	Continued From page 5 Example 4- Deck steps -Plants overgrown and obstructed exit from deck (Photo 14) Example 5- Postings -Multiple postings of information for staff and residents covered large area of living room wall left of mounted television (Photo 15) -Multiple postings of information for staff and residents covered large area of dining area wall (Photo 16). Example 6- Kitchen Cupboard -Door on upper cupboard right of sink loose and hanging lopsided (photo 17) -Broken smoke detector mount attached to wall about paper towel dispenser (photo 18) -Black smudge and gauge out of drywall (painter over) both approximate size of 50 cent piece, 1 screw serving no purpose and 3 screw holes on wall left of kitchen counter (Photo 19). Example 7- Hallway -2 switch light cover: clear tape covered half the switch cover, a hand handwritten note (stating "Light only") written on a torn piece of paper was taped to other switch cover (Photo 20). Example 8- Front porch -white railing was missing 5 spindles and a screen door was stored on the front porch area (Photo 21) -Postings adhered to front door included "NO FIREAMRS OR WEAPONS ALLOWED ON THIS PROPERTY" AND "NO SMOKING OR VAPING". An additional (typed on white paper and taped to door) sign stated "NOTICE: WEAPONS OF ANY KIND IS PROHIBITED INTO THIS HOUSE NOTICE: NO SMOKING INSIDE THIS HOUSE".	M 276		

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M 276	Continued From page 6 Four areas of what appeared to be dried tape adhesive were on the front door (2 measuring approximately 2"x 2" and 2 measuring approximately 2" x 3") (Photo 23). On 08/18/2026 at approximately 1:45 PM, Surveyor discussed concerns regarding environment with Licensee A who stated s/he did not know why the spindles were missing from the front porch rail and the screen door broke recently. Licensee A stated s/he was planning to paint the home's interior soon and the home needed to look good. Cross Reference: M0436 DHS 88.07(2)(a) Services	M 276		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department	M 332		

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and have an attached tag showing the date of the last dealer or fire department inspection.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure all required fire extinguishers were mounted.

The main floor fire extinguisher was stored in the cupboard under the kitchen sink.

Findings include:

The facility is licensed as a nonambulatory adult family home able to serve up to 4 residents within the client groups of physically disabled, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness and advanced age.

On 08/18/2026 at 1:16 PM, Surveyor observed the fire extinguisher mounting hardware attached to kitchen wall with no fire extinguisher mounted to it.

On 08/18/2026 at 1:16 PM, Surveyor interviewed Licensee A who stated when the fire extinguisher was mounted it was in the way, so s/he stored it in the cupboard under the kitchen sink (Photo 22).

On 08/18/2026 at approximately 1:45 PM, Surveyor discussed concerns regarding the main floor fire extinguisher not mounted with Licensee A who stated s/he would mount the fire extinguisher on a different wall.

Cross Reference:

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M 332	Continued From page 8 M0262 DHS 88.05(2)(a) Difficulty Walking M0334 DHS 88.05(4)(b)1 Fire Safety-Smoke Detectors M0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing And Maintenance M0346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation	M 332		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a smoke detector was on the ceiling of each habitable sleeping room in 1 of 4 bedrooms observed. The smoke detector in Resident 4's bedroom was missing from its bracket. Findings include:	M 334		

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M 334	Continued From page 9 The facility is licensed as a nonambulatory adult family home able to serve up to 4 residents within the client groups of physically disabled, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness and advanced age. On 08/18/2026 at 12:48 PM while touring home with Licensee A, Surveyor observed a smoke detector mounting hardware on Resident 4's ceiling. The smoke detector was missing from the mount. On 08/18/2026 at 12:48 PM, Surveyor interviewed Licensee A who stated Resident 4 probably threw the smoke detector away if it beeped. Licensee A retrieved a new smoke detector from storage and mounted it on the bracket. Cross Reference: M0262 DHS 88.05(2)(a) Difficulty Walking M0332 DHS 88.05(4)(a) Fire Safety-Fire Extinguishers M0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing And Maintenance M0346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation	M 334		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall	M 336		

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M 336	Continued From page 10 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 required smoke detector was tested monthly to make sure it was working. Smoke detectors were not tested monthly in 2024, 2025 or 2026. Findings include: The facility is licensed as a nonambulatory adult family home able to serve up to 4 residents within the client groups of physically disabled, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness and advanced age. On 08/18/2026 at approximately 9:30 AM, Surveyor requested 2024 and 2025 smoke detector test documentation from Licensee A, who provided 2025 and 2026 documentation. The documentation identified smoke detectors were tested on 04/20/2025, 12/14/2025, 01/16/2026 and 6/25/2026. On 08/18/2026 at 12:24 PM, Surveyor interviewed Licensee A who stated smoke detector testing was not completed monthly in 2025 or thus far during 2026. Licensee A stated staff needed to test smoke detectors monthly. On 08/18/2026 at approximately 1:45 PM, Surveyor discussed concern of not testing smoke	M 336		

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M 336	Continued From page 11 detectors monthly with Licensee A who stated s/he would provide Surveyor with 2024 smoke detector testing documentation by noon on 08/19/2026. On 08/19/2026 at 3:47 PM, Surveyor received an email from Licensee A with attached 2024 smoke detector testing documentation attached. In 2024, smoke detectors were tested in January, February, March or April. Cross Reference: M0262 DHS 88.05(2)(a) Difficulty Walking M0332 DHS 88.05(4)(a) Fire Safety-Fire Extinguishers M0334 DHS 88.05(4)(b)1 Fire Safety-Smoke Detectors M0346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation	M 336		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident was evaluated annually for evacuation time for 2 of 2 residents reviewed.	M 346		

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M 346	Continued From page 12 In 2025, the provider did not evaluate Resident 1's and Resident 2's evacuation times. Findings include: The facility is licensed as a nonambulatory adult family home able to serve up to 4 residents within the client groups of physically disabled, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness and advanced age. On 08/18/2026, Surveyor reviewed Resident 1's and Resident 2's records. Example 1- Resident 1 Resident 1 was admitted 05/16/2024. The only evacuation assessment in his/her record was dated 05/17/2024. Example 2- Resident 2 Resident 2 was admitted 05/01/2024. The only evacuation assessment in his/her record was dated 05/02/2024. On 08/18/2026 at 10:51 AM, Surveyor interviewed Licensee A who stated if s/he had observed a changed in resident's abilities to evacuate during fire drills, s/he would have updated the evacuation assessments, however neither Resident 1's or Resident 2's evacuation abilities had changed since May 2024. On 08/18/2026 at approximately 1:45 PM, Surveyor discussed concern of not completing annual evacuation assessments with Licensee A who stated s/he should have reviewed and documented "No changes" in evacuation abilities May 2025 and May 2026 for Resident 1 and Resident 2.	M 346		

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M 346	Continued From page 13 Cross Reference: M0262 DHS 88.05(2)(a) Difficulty Walking M0332 DHS 88.05(4)(a) Fire Safety-Fire Extinguishers M0334 DHS 88.05(4)(b)1 Fire Safety-Smoke Detectors M0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing And Maintenance	M 346		
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 each residents individual service plan (ISP) was reviewed at least every 6	M 424		

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months and updated in writing when the resident's needs changed.

Resident 1's ISP was not reviewed at least every 6 months and was not updated in writing when his/her mobility improved and s/he drove his/her own car. The ISP did not address Resident 1's mood and history of suicidal ideations despite Licensee A's awareness of mood, history of mental illness and suicidal ideations prior to and after admission to the adult family home.

Findings include:

On 07/09/2026, the Department received a complaint alleging staff did not recognize a resident's change in condition and resident was subsequently hospitalized.

On 0-8/18/2026 at 8:48 AM, Surveyor interviewed Licensee A who stated Resident 1 was hospitalized 07/07/2026-07/08/2026 at a mental health institute due to suicidal ideations. Licensee A stated Resident 1 was gone from the adult family home visiting family when the incident occurred, and s/he was notified by the police via a phone call that Resident 1 was hospitalized. Licensee A stated during April 2026 s/he had a conversation with Resident 1 regarding Resident 1's mood because s/he appeared to be feeling "down". Licensee A stated Resident 1 informed him/her that s/he "had a quick suicidal thought but had no plan." Licensee A stated after the conversation, s/he interviewed staff who said they had not noticed anything unusual with Resident 1.

On 08/18/2026, Surveyor reviewed Resident 1's record.
S/he was admitted 05/16/2024. Diagnoses listed on facility face sheet included anxiety disorder,

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	0020036	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEDOM GROUP HOME LLC II	3349 CLOVE DR MADISON, WI 53704

(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 15	M 424		

bipolar affective disorder, dysthymic disorder, attention deficit hyperactivity disorder, insomnia, chronic pain, phantom limb pain syndrome and left above knee amputation.

Summarization of Encounter dated 05/06/2024 listed a diagnosis of suicidal ideations.

According to Drugs.com " ...Dysthymic disorder, or dysthymia, is a type of depression that occurs over a long period of time. Dysthymia may affect how you get along with your family, friends, or other people. It may also affect your daily activities at work, home, or school ...(Source: https://www.drugs.com/cg/dysthymic-disorder.html (retrieval date 08/211/2026))."

According to the Centers for Disease Control and Prevention (CDC) " ...Suicide was responsible for 48,824 deaths in 2024. The number of people who think about or attempt suicide is even higher. In 2024, an estimated 14.3 million adults seriously thought about suicide, 4.6 million planned a suicide attempt, and 2.2 million attempted suicide ...(Source: https://www.cdc.gov/suicide/data/index.html (retrieval date 08/21/2026)).

Preadmission assessment signed and dated 05/09/2024 by Licensee A identified Resident 1 was totally dependent for ambulation with cane, required some assistance to transfer to/from bed and chair, displayed a sad or anxious mood, and was unable to drive him/herself.

Daily Progress Notes: From 06/21/2026-08/13/2026, staff documented Resident 1 drove his/her (own) car 8 times.

ISP dated 08/24/2025:

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M 424	Continued From page 16 In the area of Behavioral Intervention- "[Resident 1] may require some kind of Redirection [sic] and Give [sic] a Space [sic] to calm down" In the area of Health Monitoring- " ...Monitor mental health/physical health ..." In the area of Behavioral Goals: "Keep getting along with oters [sic]." Resident 1's ISP did not address: his/her mood or identify specific staff interventions to monitor, manage, or respond to mood and/or suicidal ideations. The ISP was not updated to identify Resident 1 was independent with transfers and mobility using crutch(es) or that s/he drove his/her car. On 08/18/2026 at approximately 1:45 PM, Surveyor discussed concern of ISP not reviewed at least every 6 months and not updated to reflect all needs and current functioning with Licensee A who stated Resident 1 had informed him/her of suicidal ideations when s/he was admitted. Licensee A stated s/he would speak with Resident 1's case manager and updated the ISP.	M 424		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure each	M 436		

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resident's individual service plan (ISP) was followed as written.

Resident 2's ISP was not followed as written, putting him/her at risk for injury, when toxic chemicals were left unsecured and an electrical outlet cover was missing in his/her room.

Findings include:
The facility is licensed as a nonambulatory adult family home able to serve up to 4 residents within the client groups of physically disabled, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness and advanced age.

On 08/18/2026, Surveyor reviewed Resident 2's record. S/he was admitted 05/01/2024. Diagnoses included anoxic brain damage and mild intellectual disabilities.

ISP dated 07/24/2026 stated " ...Securely store all knives, scissors, cutlery, cooking utensils, tools, power tools, cleansers, chemicals, medication OTCs, fire starters (matches, lighters) etc. in locked or out of reach locations ...Continue to monitor the environment daily during each shift to assess for accessible items that could cause injury or harm if accessed. This should be an ongoing and active process to promote safety in the environment ...Items that should be locked/secured at all times ...Chemicals Cleansers Fire Starters Medications ...Sharps Other ..."

On 08/18/2026 at 12:42 PM while touring home with Licensee A, Surveyor observed an electrical outlet in Resident 2's room missing it's cover (Photo 10) and unsecured chemicals stored in cupboard under kitchen sink. The locking

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mechanism on the inside of right cupboard door did not work and the locking mechanism for the left cupboard door was missing (Photo 23).

Unsecured chemicals stored in cupboard under kitchen sink included: Scrub Free Total Bathroom Cleaner (label stated " ...CAUTION: KEEP OUT OF REACH OF CHILDREN. CONTENTS UNDER PRESSURE. EYE & SKIN IRRITANT ...", Comet with bleach (Label stated " ...KEEP OUT OF REACH OF CHILDREN CAUTION: EYE AND SKIN IRRITANT ..."), Raid Flying Insect (Label stated " ...KEEP OUT OF REACH OF CHILDREN CAUTION: SEE FIRST AID AND ADDITIONAL PRECAUTIONARY STATEMENT ON BACK PANEL ..."), The Works Toilet Bowl Cleaner (Label stated " ...KEEP OUT OF REACH OF CHILDREN. CAUTION: EYE AND SKIN IRRITANT See back panel for additional precautionary statements ..."

On 08/18/2026 at 1:27 PM, Surveyor interviewed Licensee A who stated s/he did not know when the lock fell off the cupboard door under kitchen sink and it just needed to be glued back on.

On 08/18/2026 at approximately 1:45 PM, Surveyor reviewed Resident 2's ISP with Licensee A and discussed concern of unsecured chemicals with him/her. Licensee A stated chemicals "absolutely" needed to be secured for Resident 2.

Cross Reference:
M0276 DHS 88.05 (3)(a) Homelike Environment