STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020294	A. BUILDING: _____ B. WING _____	C 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHSAIDA MANASSAS	1337 MANASSAS TRAIL MADISON, WI 53718

(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 From 07/06/2026 to 07/16/2026, Surveyor conducted a complaint investigation and standard survey at Bethsaida Manassas, an AFH in Madison. Six deficiencies were identified. The complaint was substantiated. Census: 4	M 000		
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 ensure 1 of 1 residents reviewed had a service agreement completed prior to admission. Resident 1 did not have a signed service agreement. Findings include:	M 384		

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

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M 384	Continued From page 1 On 07/06/2026 at approximately 9:20 a.m., Surveyor reviewed resident records. Resident 1 was admitted to the provider's home on 12/18/2025 with diagnosis including traumatic brain injury. Resident 1 had a legal guardian. Resident 1's record did not include a service agreement. On 07/06/2026 at 10:00 a.m., Surveyor interviewed Manager A and requested documentation of Resident 1's admission paperwork, including a signed service agreement. Manager A stated s/he was on vacation at the time of Resident 1's admission, so s/he would need to reach out to Admissions E for documentation. On 07/07/2026 at 4:30 p.m., Surveyor received admission paperwork from Admissions E. The admission paperwork did not include a signed service agreement. Admissions E stated s/he did not have documentation of a signed service agreement, which should have been completed with the provider's program director at the time of admission. Admissions E stated the program director that was present at the time of Resident 1's admission was no longer working for the provider.	M 384		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan.	M 420		

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M 420	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed had an individual service plan (ISP) signed and dated by all persons involved. Findings include: On 07/06/2026 at approximately 9:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 12/18/2025 with diagnosis of traumatic brain injury. Resident 1 had a legal guardian. Manager A provided Surveyor with an individual service plan, not signed or dated, for Resident 1. On 07/06/2026 at 9:54 a.m., Surveyor interviewed Manager A and asked if Resident 1 had an ISP that had been reviewed and signed by his/her legal guardian. Manager A replied, "No," and explained that his/her printer was out of ink to print the ISP and Resident 1's guardian had not been to the home.	M 420		
M 426	88.07(1)(a) RESIDENT CARE-GENERAL REQUIREMENTS The licensee shall provide a safe, emotionally stable, homelike and humane environment for residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a safe and emotionally stable environment was provided. The behavior of Resident 2 affected the safety of other residents residing in the home.	M 426		

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M 426	Continued From page 3 Findings include: From 07/06/2026 to 07/16/2026, Surveyor conducted a complaint investigation concerning resident behavior within the home. On 07/06/2026 at 8:20 a.m., Surveyor interviewed Caregiver B regarding resident behaviors. Caregiver B stated Resident 2 had a history of getting jealous of others and attacking them. On 07/06/2026 at 9:20 a.m., Surveyor reviewed Resident 2's record. Resident 2 resided at the provider's home when the provider took over ownership on 09/01/2024. Resident 2's diagnoses included developmental disability and unspecified behavioral syndrome associated with physiological disturbance and physical factors. Resident 2's individual service plan (ISP), dated 06/16/2026, indicated s/he had a history of physical aggression, verbal aggression, self-injury and property destruction. The ISP indicated Resident 2 had a history of lashing out at staff or residents had a 1:1 staff during the day, but shared staff at night. Resident 2's progress notes, dated 01/01/2026 to 07/06/2026, documented the following behavioral concerns: - 01/15/2026: Physically attacked and tried to spit on caregiver. - 01/27/2026: Grabbed at caregiver's clothes and tried hitting him/her. As another caregiver intervened, another resident walked in the room and Resident 2 immediately went to attack the other resident. Staff intervened. - 02/13/2026: Charged at another resident out of the blue, grabbing the resident by the hair and trying to hit him/her. - 02/15/2026: Charged at caregiver out of the	M 426		

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M 426	Continued From page 4	M 426		

blue and tried to spit in caregiver's face.
- 02/18/2026: Attacked new caregiver, behavior included grabbing, hitting, verbal aggression and spitting.
- 03/02/2026: Suddenly tried to attack another resident, grabbing the resident around his/her neck from behind.
- 03/10/2026: Attacked another resident out of the blue. Resident 2 tried to grab the other resident's throat, but came short and came into contact with the resident's coat. The other resident pushed Resident 2 to protect him/herself.
- 03/12/2026: After returning from a car ride, Resident 2 ran over to another resident that was lying on the couch, grabbed the resident by the hair and started to pull while attempting to hit the resident.
- 03/28/2026: Attacked caregiver.
- 03/30/2026: Out of the blue, went after another resident, trying to hit the resident. After caregiver thought behavior was calmed, Resident 2 went after the other resident again, grabbing at clothes and trying to hit the other resident in the face. The other resident became upset and began fighting in defense.
- 04/03/2026: Attacked another resident while they were passing by. Grabbed the resident by his/her hair, was verbally aggressive and tried to hit him/her in the face.
- 04/08/2026: Attacked staff out of the blue, grabbed by hair and hit in the face. When 2 other caregivers intervened, Resident 2 directed his/her aggression at 1 of the intervening caregivers.
- 04/12/2026: Attacked another resident when they were going back to their room.
- 04/14/2026: Jumped off the couch and ran towards another resident, grabbing that resident by the back of the shirt and hitting him/her
- 04/16/2026: Halfway to Resident 2's room, Resident 2 turned around and attacked caregiver,

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M 426	Continued From page 5	M 426		

hitting and being verbally aggressive.
- 04/19/2026: Attacked another resident.
- 05/05/2026: Attacked another resident, grabbing by the shirt and attempting to hit in the face. The other resident pushed back at Resident 2.
- 05/11/2026: Attacked another housemate for no apparent reason, grabbed by the shirt.
- 05/12/2026: Attacked caregiver, pulling at clothes, hitting him/her and twisting his/her fingers. Resident 2 then began to attack another resident, grabbing his/her hoodie and trying to hit him/her in the face.
- 05/14/2026: Attacked a caregiver today.
- 05/17/2026: Attacked another resident, unprovoked.
- 06/20/2026: Attacked another resident. Tried to pull the other resident off a barstool and began hitting him/her and spit at the resident.

Resident 2's progress notes, dated 01/01/2026 to 07/06/2026, documented the following concerns related to Resident 2's behaviors affecting others:
- 03/30/2026: "This behavior has become very disruptive and unsafe and unfair for other housemates. They have to pass by [him/her] in order to get to the kitchen, dining room and to get outside for a smoke, pretty much anywhere in the house and [s/he]'s attacking EVERYONE."
- 04/08/2026: "These behaviors are becoming more frequent and unsafe for [Resident 2] and the other housemates that keep getting attacked by [him/her], especially when they feel the need to defend themselves when [Resident 2] attacks them."
- 04/14/2026: "These attacks are unpredictable and becoming more frequent and unsafe for other housemates. Its getting to the point that housemates can't leave their room or they need to be escorted passed [Resident 2]'s room into the common area/living room/kitchen out of fear

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M 426	Continued From page 6 of being attacked by [Resident 2]. - 05/05/2026: "This behavir[sic] is getting very concerning for [Resident 2] and the other housemates, especially since [Resident 4] is quit a bit bigger and getting attacked for no reason is a trigger for [Resident 4]'s anger." On 07/06/2026 at approximately 11:30 a.m., Surveyor interviewed Resident 1 regarding the care at the provider's home. Resident 1 stated his/her only concern was Resident 2 attacking him/her. On 07/16/2026 at 10:00 a.m., Surveyor interviewed Program Manager C. Surveyor reviewed each of the behavioral episodes documented in Resident 2's notes from 01/01/2026 to 07/06/2026. Program Manager C stated s/he was unaware of the number of behaviors Resident 2 exhibited. Program Manager C stated Resident 2 had not exhibited behaviors when s/he or the behavior specialist visited the home. Program Manager C stated staff should have created incident reports for each behavioral episode so that s/he and the quality department within the provider's organization would have been notified. Program Manager C stated s/he was exploring other living options for Resident 2, such as a 1-2 resident home because Resident 2 had a history of getting jealous of others.	M 426		
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.	M 436		

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M 436	Continued From page 7	M 436		

This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not ensure services specified in 2 of 2 individual service plans (ISP) reviewed were provided.

The provider did not ensure dedicated staffing was provided as indicated in Resident 1 and Resident 2's ISPs.
The provider did not ensure supervision was provided when Resident 1 was smoking.

Findings include:

From 07/06/2026 to 07/16/2026, Surveyor conducted a complaint investigation alleging behavioral concerns at the facility. The following concerns related to resident services were identified:

Dedicated Staffing:

On 07/06/2026 at 7:55 a.m., Surveyor arrived at the provider's home. Surveyor observed 2 caregivers present (Caregiver B and Caregiver C) and 4 residents present. Caregiver B stated Manager A left the home earlier to go to an affiliated home that Manager A oversaw.

On 07/06/2026 at approximately 9:00 a.m., Caregiver D and Manager A arrived at the home.

On 07/06/2026 at approximately 9:20 a.m., Surveyor reviewed 2 resident records, which documented the following:

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M 436	Continued From page 8 - Resident 1 was admitted to the provider's home on 12/18/2025 with diagnosis including traumatic brain injury. Resident 1's ISP, not dated, stated Resident 1 required 1:1 supervision 16 hours per day with shared staff overnight. - Resident 2 resided at the provider's home when the provider took ownership of the home on 09/01/2024. Resident 2's ISP, dated 06/16/2026, stated s/he required line of sight supervision, including 1:1 supervision during the day, shared staff at night. On 07/06/2026 at 10:25 a.m., Surveyor interviewed Manager A regarding staffing patterns at the home. Manager A clarified supervision requirements stating Resident 1 and Resident 2 required dedicated staffing and Resident 3 and Resident 4 required supervision but could be shared supervision. Manager A clarified that dedicated staffing hours were 7:00 a.m. to 11:00 p.m. Surveyor asked why only 2 staff were present when s/he arrived to the provider's home during dedicated staffing hours. Manager A stated s/he had to leave to go to an affiliated home for a meeting and confirmed the home should have been staffed with 3 caregivers. On 07/07/2026 at approximately 8:00 a.m., Surveyor reviewed the provider's time clock punches for 07/04/2026 and 07/05/2026, provided by Program Manager C, to clarify staffing patterns. Program Manager C stated the live-in-caregiver would have been present on the dates as well, but didn't clock in. Surveyor identified the following periods when the home was not staffed to provide supervision services identified in ISPs, even with the live-in caregiver present for the duration of the interval:	M 436		

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M 436	Continued From page 9 - 07/04/2026 7:00 a.m. to 12:10 p.m and 5:57 p.m. to 11:00 p.m. - 07/05/2026 7:00 a.m. to 8:32 a.m. and 8:05 p.m. to 11:00 p.m. Supervision: On 07/06/2026 at approximately 8:20 a.m. and 10:37 a.m., Surveyor observed Resident 1 exit his/her room, mark a piece of paper to indicate s/he was smoking, take a cigarette (unsecured) from the provider's kitchen and independently smoke cigarettes on the provider's deck. On 07/06/2026 at approximately 9:20 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 12/18/2025 with diagnosis including traumatic brain injury. Resident 1's ISP, not dated, identified safety concerns with Resident 1's smoking and indicated cigarettes and lighters were to be kept in the medication cart, dispensed on a 2-hour schedule and that standby assist was required when smoking to ensure safety. On 07/06/2026 at 12:15 p.m., Surveyor interviewed Manager A and Program Manager C. Surveyor discussed concern that Resident 1 obtained his/her smoking materials independently and smoked independently while Surveyor was present. Manager A and Program Manager C made note of Surveyor's concern.	M 436		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner.	M 474		

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M 474	Continued From page 10	M 474		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure food was prepared and stored in a sanitary manner.

Findings include:

On 07/06/2026 at approximately 8:10 a.m., Surveyor toured the provider's home. Surveyor observed the following concerns:

Refrigerator:
- A hot dog in a Ziploc bag with no date.
- Turkey and ham deli meat with no date of opening. The package stated use within 5 days of opening.
- Noodles in a disposable container with no date of opening.
- Salami deli meat with no date of opening.
- Soup in a disposable container with no date of opening.
- Rice in a disposable container with no date of opening.
- 2 food items wrapped in tinfoil with no date.
- 1 container of Chinese take out with no date.
- A Ziploc bag with a slice of pizza with no date.

Freezer:
- A Ziploc bag of greens that was not sealed and had freezer burn.

Dry Storage:
- Ramen noodles and individual bags of chips stored on the garage floor.

"Date marking is a way to control the growth of a bacteria called Listeria, which grows under

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M 474	Continued From page 11 refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) Sliced deli meat is good for 3 to 5 days after opening (Source: FoodSafety.gov, Cold Food Storage Chart, September 19, 2023, https://www.foodsafety.gov/food-safety-charts/cold-food-storage-charts (retrieval date - September 17, 2025).) "If you do not seal your food it can get "freezer-burn". This means that water escapes from the food and moves to the coldest part of the freezer - leaving your food dehydrated." (Source: Safefood website, Storing food in the freezer, 2024, https://www.safefood.net/food-storage/freezing (retrieval date - January 2, 2025).) On 07/06/2026 at approximately 8:20 a.m., Surveyor reviewed food safety and storage concerns with Caregiver B. Caregiver B stated some of the items were for staff, some items s/he knew were opened or prepared the day prior and some items were Resident 1's individual food brought by family. Surveyor observed items for staff, all residents and Resident 1 were stored throughout the refrigerator and not in a designated area, leaving it unknown what food belonged to who.	M 474		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents,	M 570		

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M 570	Continued From page 12 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 environment. The provider's dryer had a semi-rigid dryer vent. Findings include: On 07/06/2026 at 8:34 a.m., Surveyor toured the provider's laundry room with Caregiver B and observed a semi-rigid dryer vent. On 07/06/2026 at 12:15 p.m., Surveyor interviewed Manager A and Program Manager C. Surveyor discussed concern that the provider's dryer was equipped with a semi-rigid dryer vent. Program Manager C made note of Surveyor's concern and stated s/he would address it.	M 570		