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	0019517	A. BUILDING: _____ B. WING _____	C 11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRACLES HOUSE	**443 S 5TH AVE WEST BEND, WI 53095**

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M 000	INITIAL COMMENTS On 11/11/2025, Surveyors conducted a standard survey and two complaint investigations at Miracles House, an Adult Family Home (AFH) in West Bend, WI. Fourteen deficiencies identified. Eight of fourteen are repeat deficiencies. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023. Two of 2 complaints substantiated. Census: 4	M 000		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure 2 of 3 caregivers reviewed were screened for illness detrimental to residents, including for tuberculosis within 90 days before the start of providing care. Caregiver B and Caregiver C did not have tuberculosis tests completed within 90 days prior to providing care.	M 232		

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

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M 232	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023. Findings include: On 11/11/2025 at approximately 11:15 AM, Surveyor conducted a review of 3 employee records, which were provided by Licensee A. Surveyor noted the following concerns: - Caregiver B was hired 07/18/2023. Caregiver B's record did not include a tuberculosis test. - Caregiver C was hired 7/11/2025. Caregiver C's record did not include a tuberculosis test. On 11/11/2025 at approximately 1:15 PM., Surveyor reviewed concern with Licensee A that 2 of 3 caregivers reviewed were not screened for illness detrimental to residents, including tuberculosis, within 90 days prior to the start of proving care and at no point thereafter. Concern of health screenings not being completed was addressed in October 2023 during a previous survey. Licensee A stated s/he wasn't aware the staff did not have the test done and will be making an appointment as soon as possible.	M 232		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes.	M 344		

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M 344	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not review the fire safety evacuation plan with 1 of 1 resident (Resident 4) reviewed immediately following his/her placement. Resident 4 did not have a fire evacuation plan within 3 days of admission. Findings include: On 11/11/2025 at approximately 11:30 AM, Surveyor reviewed Resident 4's record and identified the following: -Resident 4 was admitted to the facility on 05/06/2025. Resident 4 did not have evidence of a fire safety evacuation plan completed within 3 days of admission. On 11/11/2025 at 12:00 PM, Surveyors interviewed Licensee A. Licensee A stated s/he did not do any paperwork for Resident 4 because s/he was just going to be a respite stay and did not know s/he was supposed to do any paperwork. Licensee A acknowledged Resident 4 had been at the facility for approximately 6 months and would not be considered a respite since it had been over 28 days. Licensee A stated s/he had been in contact with Resident 4's managed care organization regarding Resident 4.	M 344		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using	M 346		

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M 346	Continued From page 3 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 facility did not evaluate 1 of 1 resident (Resident 3) reviewed annually for his/her evacuation time, using the department's form. Findings include: On 11/11/2025 at approximately 10:30 AM, Surveyor reviewed Resident 3's medical record. Resident 3 was admitted to the facility on 09/09/2024. Review of Resident 3's medical records showed Resident 3's initial evacuation evaluation was conducted on 09/10/2024. Resident 3's annual evaluation for evacuation was due to be reviewed by 09/10/2025. There was no record of evidence of a 2025 evacuation evaluation in Resident 3's medical record. On 11/11/2025 at approximately 1:00 PM, Surveyor requested documentation from Licensee A of Resident 3's annual evacuation evaluation. Licensee A stated that he/she was on vacation and behind on paperwork so one was not completed.	M 346		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the	M 380		

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M 380	Continued From page 4	M 380		

licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 3 and Resident 4) reviewed received a health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission or within 7 days after admission.

This is a repeat deficiency. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023.

Findings include:

On 11/11/2025 at approximately 10:30 AM, Surveyors reviewed Resident 3's and 4's records, including their communicable disease screens and health exams.

-Resident 3 was admitted to the facility on 09/09/2024. Resident 3's record did not include evidence of a communicable disease screening, including a TB skin test or a health exam.
-Resident 4 was admitted to the facility on 05/06/2025. Resident 4's record did not include

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M 380	Continued From page 5 evidence of a communicable disease screening, including a TB skin test or a health exam. On 11/11/2025 at approximately 1:00 PM, Surveyor interviewed Licensee A regarding the admission health exam for Resident 3 and Resident 4. Licensee A reviewed Resident 3's medical record and stated s/he thought s/he had an exam before s/he was admitted. Licensee A stated Resident 4 was originally admitted as respite, but had been at the facility for about 6 months and over the allotted days of respite. Licensee A stated s/he did not receive any paperwork on him/her. Licensee A was not able to provide evidence of a communicable disease screening, including TB skin test or an admission health exam for Resident 3 and Resident 4.	M 380		
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 resident (Resident 4) reviewed had a service agreement completed	M 384		

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M 384	Continued From page 6 prior to admission that was signed. This is a repeat deficiency. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023. Findings include: On 11/11/2025 at approximately 11:30 AM, Surveyors reviewed Resident 4's record and identified the following: -Resident 4 was admitted to the provider on 05/06/2025. Resident 4's record did not contain evidence of a service agreement. On 11/11/2025 at 12:00 PM, Surveyors interviewed Licensee A. Licensee A stated s/he did not do any paperwork for Resident 4 because s/he was just going to be a respite stay and did not know s/he was supposed to do any paperwork. Licensee A acknowledged Resident 4 had been at the facility for approximately 6 months and would not be considered a respite since it was over 28 days. Licensee A stated s/he had been in contact with Resident 4's managed care organization regarding Resident 4.	M 384		
M 402	88.06(2)(c)8 RESIDENT RIGHTS AND GRIEVANCE A statement indicating that the resident rights and grievance procedures have been explained and copies provided to the resident and the resident's guardian or designated representative, if any. This Rule is not met as evidenced by: Based on record review and interview, the	M 402		

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M 402	Continued From page 7 provider did not ensure 1 of 1 resident (Resident 4) admitted to the home had a statement indicating resident rights and grievance procedures had been explained and copies provided to the resident and resident's guardian or designated representative, if any. Findings include: On 11/11/2025, Surveyors reviewed Resident 4's record and identified the following: -Resident 4 was admitted to the provider on 05/06/2025. Resident 4's record did not contain evidence of resident rights and grievance procedures explained with resident and/or resident's guardian. On 11/11/2025 at 12:00 PM, Surveyors interviewed Licensee A. Licensee A stated s/he did not do any paperwork for Resident 4 because s/he was just going to be a respite stay and did not know s/he was supposed to do any paperwork. Licensee A acknowledged Resident 4 had been at the facility for approximately 6 months and would not be considered a respite since it was over 28 days. Licensee A stated s/he had been in contact with Resident 4's managed care organization regarding Resident 4.	M 402		
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		

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M 404	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written assessment and individual service plan (ISP) was completed for 1 of 1 resident (Resident 4) within 30 days of placement. This is a repeat deficiency. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023. Findings include: On 11/11/2025, Surveyors reviewed Resident 4's record and identified the following: -Resident 4 was admitted to the facility on 05/06/2025. -Resident 4's record did not contain a written assessment -Resident 4's record did not contain an ISP. On 11/11/2025 at 12:00 PM, Surveyors interviewed Licensee A. Licensee A stated s/he did not do any paperwork for Resident 4 because s/he was just going to be a respite stay and did not know s/he was supposed to do any paperwork. Licensee A acknowledged Resident 4 had been at the facility for approximately 6 months and would not be considered a respite since it was over 28 days. Licensee A stated s/he had been in contact with Resident 4's managed care organization regarding Resident 4.	M 404		
M 414	88.06(3)(d)2 LEVEL OF SUPERVISION Identification of the level of	M 414		

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M 414	Continued From page 9 supervision required in the home and community. 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 plan (ISP) addressed the level of supervision required in the community. Resident 1 was assessed as needing 1:1 dedicated staff member 24 hours a day. Resident 1 was left unattended in at a hospital for approximately 7 hours. Findings include: This provider is licensed to serve up to 4 residents within the client groups of physically disabled; traumatic brain injury; developmentally disabled; emotionally disturbed/mental Illness; advanced age; terminally ill; and irreversible dementia/Alzheimer's. On 11/11/2025, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 06/19/2025 with diagnoses of diabetes mellitus, anxiety and depression.. Resident 1 has a guardian. Resident 1's current individual service plan (ISP), dated 07/02/2025, indicated the following: -"[Resident 1] has a guardian and cannot be in the home or in the community without supervision of AFH staff. [Resident 1] has no restrictive measures in place. [Resident 1] will use the transportation of the AFH or any transportation that is set up by the AFH owner but must adhere to any rule and regulations regarding traveling outside of the home." -"[Resident 1] will be supervised daily and	M 414		

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overnight by providers or substitute providers who are at least 18 years of age and have an up to date criminal background check with AFH. [Resident 1] has a guardian and therefore [s/he] can come and go from AFH facility with AFH owner/staff. [Resident 1] requires 1:1 supervision at all times 24/7."

-Resident 1's progress notes stated the following on 10/28/2025:
"-Around 6:30 PM, [Resident 1] told [Licensee A] [his/her] stomach hurts. [Licensee A] was busy making dinner and the other staff was toileting residents. [Licensee A] offered [Resident 1] a Tylenol for [his/her] cramps and stomach. [S/he] refused it so [Licensee A] told [him/her] [s/he] would be able to go around 7:00 PM. Around 6:45 PM, [Licensee A] received a call from [Resident 1's] guardian claiming [Resident 1] stated [Licensee A] said [s/he] would not take [Resident 1] to urgent cares. [Licensee A] told [Resident 1's] guardian [s/he] didn't say that and called [Resident 1] into the kitchen while being on the phone with [Resident 1's guardian]. [Resident 1] got upset and walked/stormed off and went out the house. [S/he] then started to call the police. The police arrived and talked to [Resident 1] and [Licensee A]. [Resident 1] then got picked up by ambulance and left. Since [Resident 1] went to hospital, [Licensee A] did not need to provide 1:1 for [Resident 1] so [Licensee A] went home for the night. [Resident 1] came back at 1:30 AM/2:00 AM."

West Bend Police Report dated 10/28/2025 at 7:40 PM stated the following:
"-On 10/28/2025 at 7:40 PM, [Officer D] and [Officer E] were dispatched to Miracles House, for a welfare check. Dispatch advised the complainant, [Resident 1], stated [s/he] had on

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going issues with group home owner, [Licensee A], and was currently locked out of the residence. Upon arrival, made contact with [Resident 1] as [s/he] was seated on the south side of the residence. As I was about to speak with [Resident 1], [Licensee A] walked to the south side of the residence and stood approximately ten feet away from [Resident 1]. [Resident 1] became visibly upset when [s/he] observed [Licensee A] nearby and did not want to speak with me. I asked [Licensee A] to wait near the front of the residence and [Licensee A] stated [s/he] wanted to make sure [Resident 1] wasn't 'lying on [him/her].' [Resident 1] walked away from the area and began to cry. [Resident 1] expressed [s/he] was frustrated with the care [s/he] had been receiving in [Licensee A's] presence.
[Resident 1] stated [s/he] had been upset with [Licensee A] because earlier, [Resident 1] had requested to seek medical care at [medical hospital's] urgent care. [Resident 1] stated [s/he] currently had pain on the left side of [his/her] body which wrapped around [his/her] abdominal area and [his/her] back. [Resident 1] stated [s/he] had colon issues and know if [s/he] was not checked out, [his/her] symptoms could worsen. [Resident 1] stated [s/he] had contacted [his/her] guardian, and advised [Guardian F] of the issue. [Resident 1] stated [Guardian F] spoke with [Licensee A] over the phone and advised [Licensee A] to take [Resident 1] to urgent care around 6:00 PM. [Resident 1] stated [Licensee A] never took [him/her] to urgent care and [his/her] symptoms remained. [Resident 1] stated [Licensee A] then let [Resident 1's] dog out of the house which cause [Resident 1] to run after the dog in the yard. [Resident 1] stated as [s/he] attempted to go back inside the house, the door was locked. [Resident 1] then stated [s/he] called the on call

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number for [Guardian F's] office and spoke with a subject who advised [him/her] to contact law enforcement. [Resident 1] stated while [s/he] was on the phone, [Licensee A] asked [him/her] to take [his/her] medications, but due to [Resident 1] being on the phone, [s/he] did not answer [Licensee A]. [Resident 1] stated [Licensee A] advised [s/he] was going to mark [Resident 1] refused to take [his/her] medications. [Resident 1] stated [s/he] never refused to take the medications.
Contact was then made with [Licensee A]. [Licensee A] advised [Resident 1] complaint of stomach pain during the day. [Licensee A] stated [s/he] called a nursing phone line who advised [Resident 1] should be taken to urgent care. [Licensee A] stated [s/he] planned to take [Resident 1] around 7:00 PM. [Licensee A] stated [s/he] then had to make dinner as the evening went on, around 7:00 PM, [s/he] had a phone visit with [his/her] incarcerated [spouse]. When confronted on the importance of the phone call versus [Resident 1] receiving medical care, [Licensee A] stated [s/he] was still cleaning up from dinner at that time while being on the phone. [Licensee A] also informed [s/he] was "not missing" [his/her] phone visit. [Licensee A] stated [s/he] let out [Resident 1's] dog in the front yard as it was time for it to use the restroom since [Resident 1] was elsewhere. [Licensee A] stated if [Resident 1] sought medical care at the hospital since urgent care clinics were currently closed, [s/he] didn't know how [Resident 1] was going to get back to the group home.
[Resident 1] allowed me to speak with [Guardian F's] office and they advised they would allow [Resident 1] to seek medical care and be transported by ambulance to a hospital. An ambulance was requested to the scene and transported [Resident 1] to the hospital.

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M 414	Continued From page 13 [Licensee A] was advised of this and expressed issues with [Resident 1's] dog which [Licensee A] allowed at the group home. [Licensee A] stated the dogs barking was disturbing the other residents. [Licensee A] was advised to communicate the issue with [Resident 1's] guardian as the dog could not be removed from the residence lawfully without [Resident 1] or [his/her] guardian's permission. [Licensee A] shut the front door of the group home after this and advised [s/he] was done speaking with officers." On 11/11/2025 at approximately 2:30 PM, Surveyors interviewed Licensee A. Licensee A stated Resident 1 is a 1:1 and needs supervision 24/7. Licensee A stated there are dedicated staff to Resident 1. Licensee A acknowledged Resident 1 was left unsupervised when taken to the hospital on 10/28/2025. Licensee A stated Resident 1 has gone to hospital by him/herself multiple times. Licensee A stated s/he would start sending staff with Resident 1 if s/he has to go out to the hospital or doctor visits moving forward.	M 414		
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. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure 1 of 1 individual service plans (ISP) reviewed included a statement of agreement with the plan, signed and dated by all persons involved. Resident 3's ISP was not	M 420		

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M 420	Continued From page 14 signed Resident 3 who is responsible for him/herself and was also not signed by Resident 3's case manager from the placing agency. This is a repeat deficiency. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023. Findings include: On 11/11/2025 at approximately 10:30 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's home on 09/09/2024. Resident 3 had a case-manager and is responsible for him/herself. Resident 3's record included an ISP, dated 09/09/2024. It was noted that Resident 3 had signed the service/admission agreement on 09/09/2024. The ISP was not signed or dated by the case manager from the placing agency or Resident 3. The ISP stated verbal consent was given by Resident 3 on 09/09/2024 and 09/30/2024 verbal consent by the case manager. On 11/11/2025 at approximately 1:15 PM., Surveyor asked Licensee A why Resident 3's record was not signed by Resident 3 or his/her case manager from the placing agency. Licensee A replied, "I don't know why."	M 420		
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	M 424		

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M 424	Continued From page 15 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 reviewed (Resident 3) service plan was reviewed at least once every 6 months by the licensee, the resident and the placing agency, to determine the appropriateness of the care plan and to update the care plan as necessary. Findings include: On 11/11/2025, Surveyor conducted a complaint investigation and standard survey. As part of the survey process, Surveyor requested to review Resident 3's record. Resident 3 was admitted to the facility on 09/09/2024. Surveyor requested to review Resident 3's most recently signed and dated Individual Service Plan (ISP). Licensee A located the most recent ISP, which was dated 03/28/2025 and located in Resident 3's chart. Surveyor noted that Resident 3's most recent ISP should have been completed in September, 2025. On 11/11/2025, Surveyor interviewed Licensee A regarding Resident 3 not having an ISP that was	M 424		

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M 424	Continued From page 16 reviewed and updated in September, 2025. Licensee A stated that s/he was on vacation and is behind on paperwork.	M 424		
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, the facility did not keep a current record of medical visits, reports and recommendations for Resident 1 and Resident 3. This is a repeat deficiency. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023. Findings include: On 11/11/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 1 and Resident 3's record and identified the following: Resident 1 -Resident 1 was admitted to the provider's home at 06/19/2025 with diagnoses of diabetes mellitus, anxiety and depression. -Resident 1's record did not include records of medical visit 10/28/2025. -Resident 1's progress notes stated the following on 10/28/2025: "Around 6:30 PM, [Resident 1] told [Licensee A] [his/her] stomach hurts. [Licensee A] was busy making dinner and the other staff was toileting residents. [Licensee A] offered [Resident 1] a Tylenol for [his/her] cramps and stomach. [S/he] refused it so [Licensee A]	M 446		

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M 446	Continued From page 17	M 446		

told him/her s/he would be able to go around 7:00PM. Around 6:45 PM, [Licensee A] received a call from [Resident 1's] guardian claiming [Resident 1] stated [Licensee A] said [s/he] would not take [Resident 1] to urgent cares. [Licensee A] told [Resident 1] guardian [s/he] didn't say that and called [Resident 1] into the kitchen while being on the phone with [Resident 1's guardian]. [Resident 1] got upset and walked/stormed off and went out the house. [S/he] then started to call the police. The police arrived and talked to [Resident 1] and [Licensee A]. [Resident 1] then got picked up by ambulance and left. Since [Resident 1] went to hospital, [Licensee A] did not need to provide 1:1 for [Resident 1] so [Licensee A] went home for the night. [Resident 1] came back at 1:30 AM/2:00AM."
-West Bend Police Report dated 10/28/2025 at 7:40 PM stated the following: "On 10/28/2025 at 7:40 PM, Officer D and Officer E were dispatched to Miracles House, for a welfare check. Dispatch advised the complainant, [Resident 1], stated [s/he] had on going issues with group home owner, [Licensee A], and was currently locked out of the residence.
Upon arrival, made contact with [Resident 1] as [s/he] was seated on the south side of the residence. As I was about to speak with [Resident 1], [Licensee A] walked to the south side of the residence and stood approximately ten feet away from [Resident 1]. [Resident 1] became visibly upset when [s/he] observed [Licensee A] nearby and did not want to speak with me. I asked [Licensee A] to wait near the front of the residence and [Licensee A] stated [s/he] wanted to make sure [Resident 1] wasn't "lying on [him/her]." [Resident 1] walked away from the area and began to cry. [Resident 1] expressed [s/he] was frustrated with the care [s/he] had been receiving in [Licensee A's]

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M 446	Continued From page 18	M 446		

presence.
[Resident 1] stated [s/he] had been upset with [Licensee A] because earlier, [Resident 1] had requested to seek medical care at [medical hospital's]] urgent care. [Resident 1] stated [s/he] currently had pain on the left side of [his/her] body which wrapped around [his/her] abdominal area and [his/her] back. [Resident 1] stated [s/he] had colon issues and know if [s/he] was not checked out, [his/her] symptoms could worsen. [Resident 1] stated [s/he] had contacted [his/her] guardian, [Guardian F] and advised [Guardian F] of the issue. [Resident 1] stated [Guardian F] spoke with [Licensee A] over the phone and advised [Licensee A] to take [Resident 1] to urgent care around 6:00 PM. [Resident 1] stated [Licensee A] never took [him/her] to urgent care and [his/her] symptoms remained. [Resident 1] stated [Licensee A] then let [Resident 1's] dog out of the house which cause [Resident 1] to run after the dog in the yard. [Resident 1] stated as [s/he] attempted to go back inside the house, the door was locked. [Resident 1] then stated [s/he] c called the on call number for [Guardian F's] office and spoke with a subject who advised [him/her] to contact law enforcement. [Resident 1] stated while [s/he] was on the phone, [Licensee A] asked [him/her] to take [his/her] medications, but due to [Resident 1] being on the phone, [s/he] did not answer [Licensee A]. [Resident 1] stated [Licensee A] advised [s/he] was going to mark [Resident 1] refused to take [his/her] medications. [Resident 1] stated [s/he] never refused to take the medications.
Contact was then made with [Licensee A]. [Licensee A] advised [Resident 1] complaint of stomach pain during the day. [Licensee A] stated [s/he] called a nursing phone line who advised [Resident 1] should be taken to urgent care. [Licensee A] stated [s/he] planned to take

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[Resident 1] around 7:00 PM. [Licensee A] stated [s/he] then had to make dinner as the evening went on, around 7:00 PM, [s/he] had a phone visit with [his/her] incarcerated [spouse]. When confronted on the importance of the phone call versus [Resident 1] receiving medical care, [Licensee A] stated [s/he] was still cleaning up from dinner at that time while being on the phone. [Licensee A] also informed [s/he] was "not missing" [his/her] phone visit. [Licensee A] stated [s/he] let out [Resident 1's] dog in the front yard as it was time for it to use the restroom since [Resident 1] was elsewhere. [Licensee A] stated if [Resident 1] sought medical care at the hospital since urgent care clinics were currently closed, [s/he] didn't know how [Resident 1] was going to get back to the group home.
[Resident 1] allowed me to speak with [Guardian F's] office and they advised they would allow [Resident 1] to seek medical care and be transported by ambulance to a hospital. An ambulance was requested to the scene and transported [Resident 1] to the hospital.
[Licensee A] was advised of this and expressed issues with [Resident 1's] dog which [Licensee A] allowed at the group home. [Licensee A] stated the dogs barking was disturbing the other residents. [Licensee A] was advised to communicate the issue with [Resident 1's] guardian as the dog could not be removed from the residence lawfully without [Resident 1] or [his/her] guardian's permission. [Licensee A] shut the front door of the group home after this and advised [s/he] was done speaking with officers."

On 11/11/2025 at approximately 1:00 PM, Surveyors interviewed Licensee A. Licensee A stated s/he was going to take Resident 1 to urgent care but s/he did not give him/her time to. Licensee A stated s/he did not know where the

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after visit summary was regarding when Resident 1 went to the hospital on 10/28/2025.

Resident 3
-Resident 3 was admitted to the provider's home on 09/09/2024 with diagnoses of acute respiratory failure, asthma, anxiety, hyperglycemia and hypertension.
-Resident 3's record did not include any records of medical visits.

On 11/11/2025 at approximately 10:45 AM, Surveyors interviewed Resident 3. Resident 3 stated s/he had lived at the group home for awhile. Resident 3 stated s/he does not need much help from the caregivers there and typically does his/her things and will ask for help if s/he needs it. Resident 3 stated s/he had just returned from a doctor's appointment. Resident 3 stated s/he had cancer and s/he has visits every 3-6 months.
-Resident 3's record did not include any records of medical visits.

On 11/11/2025 at approximately 1:30 PM, Surveyors interviewed Licensee A if Resident 3 had completed medical visits while residing at the home. Licensee A stated Resident 3 pretty much manages his/her doctor's appointments. Licensee A stated that Resident 3 did have a medical appointment scheduled for 10/26/2025 but s/he did not make it because Licensee A had a medical appointment scheduled for him/herself and Resident 3 told him/her just to go to her appointment and reschedule his/hers. The appointment was rescheduled for 11/13/2025. Licensee A could not locate any after visit summaries or doctor office visits for Resident 3 in his/her record.

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M 464	Continued From page 21	M 464		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician for 1 of 1 resident reviewed who required staff to administer their medications. Resident 3 did not have a written order permitting the provider staff to administer medications. This is a repeat deficiency. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023. Findings include: On 11/11/2025 at approximately 11:30 a.m., Surveyor reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 09/09/2024. -Resident 3's medications were administered by the home's caregivers. Resident 3's record did not include a physician order to administer medications.	M 464		

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M 464	Continued From page 22 On 11/11/2025 at approximately 12:00 PM, Surveyors interviewed Licensee A. Licensee A stated Resident 3 has an appointment coming up and will get signed orders at that time. Licensee A could not provide additional evidence that Resident 3 had previous signed physician orders to administer Resident 3's medications.	M 464		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 1 had physical and emotional privacy in living arrangements. Two nail hooks were observed where a sheet was hung for Resident 1's door when Licensee A removed the door. This is a repeat deficiency. See Statement of Deficiency (SOD) ZYJY11, dated 10/13/2023.	M 550		

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M 550	Continued From page 23 Findings include: On 11/11/2025 at approximately 10:30 AM, Surveyors conducted an onsite tour with Caregiver B. Surveyor observed two nails sticking out of the wall above the door frame of Resident 1's door. Surveyors asked Caregiver B what the nails were for. Caregiver B stated Resident 1's door was taken off, when s/he was slamming the door and was having his/her episodes. Caregiver B stated the door was off for probably a week or two. Caregiver B stated the nails were there so a sheet cover could be placed over the door. On 11/11/2025 at approximately 1:00 PM, Surveyors interviewed Resident 1. Resident 1 stated Licensee A had taken the door off because s/he sometimes has a tendency to slam his/her door shut when s/he becomes upset with staff or Licensee A. Resident 1 stated s/he had no privacy for about two weeks because s/he had no door and it was hard to keep his/her dog in his/her room due to there being no door. On 11/11/2025 at approximately 2:00 PM, Surveyors interviewed Licensee A. Licensee A stated Resident 1 slams his/her door often and s/he had slammed the door on one of his/her caregivers. Licensee A stated the hinge had come off so the door was removed and Resident 1 did not have a door on his/her room for about a week or two. Licensee A stated s/he had put up a sheet to cover the door until his/her maintenance person could come fix it.	M 550		
M 582	88.10(3)(q) Medications Medications. To receive all	M 582		

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prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency.

This Rule is not met as evidenced by:
Based on record review and interview, 2 of 2 residents reviewed (Resident 1 and Resident 3) did not receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 missed a total of 8 medication doses and Resident 3 missed a total of 20 medication doses.

Findings include:

On 11/11/2025 at approximately 12:30 PM, Surveyors reviewed Resident 1 and Resident 3's record and identified the following:

Resident 1 was admitted to the provider's home on 06/19/2025. Resident 1's MAR (medication administration record) for the month of November 2025 had the following blank entries:
-Melatonin 5 milligram (mg) tablet by mouth at bedtime-11/07/2025, 11/08/2025, 11/09/2025 and 11/10/2025.
-Sertraline 100 milligram (mg) tablet. Take two tablets by mouth daily for depression-11/07/2025, 11/08/2025, 11/09/2025 and 11/10/2025.

Resident 3 was admitted to the provider's home on 09/09/2024. Resident 3's MAR (medication

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administration record) for the month of November 2025 had the following blank entries:
-Magnesium oxide 400 milligram (mg) tablet every morning- 11/07/2025, 11/08/2025, 11/09/2025, 11/10/2025 and 11/11/2025.
-Prednisone 10 milligram tablet every morning- 11/07/2025, 11/08/2025, 11/09/2025, 11/10/2025 and 11/11/2025.
-Sodium Chloride 1 GM every morning-11/07/2025, 11/08/2025, 11/09/2025, 11/10/2025 and 11/11/2025.
-Trazadone 100 milligrams every night at bedtime- 11/10/2025.
-Atorvastatin 80 milligrams 1 tablet every night at bedtime-11/07/2025, 11/08/2025, 11/09/2025 and 11/10/2025.

On 11/11/2025 at approximately 1:30 PM, Surveyors interviewed Licensee A. Licensee A stated that for those medications not signed out, it is because Resident 1 and Resident 3 did not get them. Licensee A stated s/he is in the process of switching pharmacies and the medications were not available to be administered to Resident 1 and Resident 3.