STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020994	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE ADULT FAMILY HOMES	1962 GREEN TREE RD 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 03/31/2026, Surveyors conducted a monitoring visit at New Life Adult Family Homes, an Adult Family Home (AFH) in West Bend, WI. Six deficiencies identified. Census: 3	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not report to the Department of a significant change in a resident's status for 1 of 1 resident (Resident 1). On 12/25/2025, Resident 1 was taken into custody by law enforcement and arrested due to increased behaviors. The incident was not reported to the Department. Findings include: Resident 1 was admitted to the facility on 11/24/2025.	M 134		

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

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M 134	Continued From page 1 On 03/31/2026 at 08:00 AM, Surveyor reviewed Police Report dated 12/25/2025 and stated the following: "On 12/25/2025, at approximately 2039 hours, Officers were dispatched to [New Life Adult Family Home] for a Disorderly Conduct complaint. Group Home Employee [Licensee A], advised that resident [Resident 1], was out of control, screaming and yelling, and unable to calm down. Upon arrival, Officers were speaking with [Resident 1] outside of the residence, and [s/he] was yelling random sentences. [Licensee A] said today was fine, but about ten minutes ago prior to Officers arrival, [Resident 1] was given [his/her] nightly medication, and [s/he] went out the front door for a cigarette. [Licensee A] said [s/he] was in the kitchen when [s/he] heard [Resident 1] screaming and yelling outside. [Licensee A] said [Resident 1] was yelling profanely at nearby neighbors and yelling loudly. [Licensee A] said [s/he] told [Resident 1] to stop yelling and screaming as [s/he] stood behind the front door. [Licensee A] said [Resident 1] said, "You better not f*cking come out here," and then proceeded to kick the front door multiple times. [Licensee A] said no other threats were made other than [his/her] swearing and yelling. [Licensee A] said [s/he] did not know what would have caused this kind of behavior. [Licensee A] said [Resident 1] does not have a legal guardian and is able to make [his/her] own decisions. Following conversation with [Licensee A], [Resident 1] entered the residence and walked up to [Officer] without saying anything. [Resident 1] was within arms length and said, "You are going to let me get this close to you?" [Officer] pushed [Resident 1] back, and [s/he] proceeded to kick [him/her] in the upper thigh of [his/her] left leg. [Resident 1] made the statement, "There, I killed you." Officers grabbed [Resident 1]'s arms and	M 134		

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M 134	Continued From page 2	M 134		

walked [him/her] over to a wall by the stairs. [Resident 1] was placed against the wall in a stabilization technique. Officer secured [Resident 1's] arm and [his/her] left leg against the wall. Once [Resident 1] was secured against the wall, Officers placed [him/her] in handcuffs, and both searched [Resident 1], resulting in no contraband being found. While stabilizing [Resident 1] against the wall, [Resident 1's] arms and legs were tense, and [s/he] would occasionally jerk [his/her] head in an attempt head butt Officers. [Resident 1] would make the comment that [s/he] "killed me" when [s/he] attempted to jerk [his/her] body or head in the officer's direction. [Resident 1] was placed in hobble restraints around both [his/her] legs to keep [him/her] from attempting to kick and head butt Officers. Officers escorted [Resident 1] to squad car and placed [him/her] in the rear of the squad. Officers transported [Resident 1] to the Washington County Jail and spoke with Acute Care Services due to [Resident 1's] behavior. Acute Care Services advised [Resident 1] could be placed in jail with no further issues. It should be noted that [Resident 1] did not mention any thoughts of self-harm or suicide. On 12/25/2025, at approximately 2200 hours, [Resident 1] was turned over to jail without incident."

On 03/31/2026 at approximately 10:00 AM, Surveyors interviewed Licensee A. Licensee A stated Resident 1 was taken into jail on 12/25/2026 and did not return until s/he was able to make his/her cash bond. Licensee A stated Resident 1 returned back to the facility sometime in the beginning of January 2026. Surveyors asked if Licensee A self-reported the incident to the Department. Licensee A stated s/he did not.

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NEW LIFE ADULT FAMILY HOMES	1962 GREEN TREE RD WEST BEND, WI 53090

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M 278	Continued From page 3	M 278		
M 278	88.05(3)(b) FREE OF HAZARDS The home shall be free from hazards and kept uncluttered and free of dangerous substances, insects and rodents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was free from hazards. The deck off one of the primary emergency exits had a large piece missing. Findings includes: The licensee can serve up to 4 residents with the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, alcohol/drug dependent, correctional clients, developmentally disabled, advanced aged, public funding, terminally ill and emotionally disturbed/mental illness. The facility census was 3 residents who were able to ambulate through the home without assistance. On 03/31/2026 at approximately 9:35 AM, Surveyors toured the facility and observed the following: Front porch (identified as emergency exit) - broken/missing wood porch boards (3 feet by 2 feet). On 03/31/2026 at approximately 10:30 AM, Surveyors interviewed Licensee A regarding hazardous condition of front porch. Licensee A	M 278		

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M 278	Continued From page 4 stated s/he had noticed it for about a week now and is not sure what had happened. Licensee A thought it could have been from the salt during the winter that made the wood break off. Licensee A acknowledged the front door off the porch is an emergency exit and it could be hazardous to the residents that live there and identified that is where residents often go outside to smoke.	M 278		
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 update the Individual Service Plan (ISP) when there was a change of condition	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 424	Continued From page 5	M 424		

for 2 of 2 residents (Resident 1 and Resident 2). Resident 1 and Resident 2 were displaying behaviors that needed to have monitoring or interventions and the ISPs were not updated to reflect the changes.

Findings include:

On 03/31/2026 at approximately 10:00 AM, Surveyors reviewed Resident 1 and Resident 2's record and identified the following:

Resident 1
-Resident 1 was admitted to the provider's home on 11/24/2025 and was his/her own person. Resident 1's current ISP was dated for 11/25/2025. Resident 1's ISP stated the following:
"Behavioral Intervention: Any teaching or redirection required by the AFH provider? Please specify and attach BSP: None"
-Resident 1's police report dated 12/25/2025 stated the following:
"On 12/25/2025, at approximately 2039 hours, Officers were dispatched to [New Life Adult Family Home] for a Disorderly Conduct complaint. Group Home Employee [Licensee A], advised that resident [Resident 1], was out of control, screaming and yelling, and unable to calm down. Upon arrival, Officers were speaking with [Resident 1] outside of the residence, and [s/he] was yelling random sentences. [Licensee A] said today was fine, but about ten minutes ago prior to Officers arrival, [Resident 1] was given [his/her] nightly medication, and [s/he] went out the front door for a cigarette. [Licensee A] said [s/he] was in the kitchen when [s/he] heard [Resident 1] screaming and yelling outside. [Licensee A] said [Resident 1] was yelling profanely at nearby neighbors and yelling loudly. [Licensee A] said

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M 424	Continued From page 6 [s/he] told [Resident 1] to stop yelling and screaming as [s/he] stood behind the front door. [Licensee A] said [Resident 1] said, "You better not f*cking come out here," and then proceeded to kick the front door multiple times. [Licensee A] said no other threats were made other than [his/her] swearing and yelling. [Licensee A] said [s/he] did not know what would have caused this kind of behavior. [Licensee A] said [Resident 1] does not have a legal guardian and is able to make [his/her] own decisions. Following conversation with [Licensee A], [Resident 1] entered the residence and walked up to [Officer] without saying anything. [Resident 1] was within arms length and said, "You are going to let me get this close to you?" [Officer] pushed [Resident 1] back, and [s/he] proceeded to kick [him/her] in the upper thigh of [his/her] left leg. [Resident 1] made the statement, "There, I killed you." Officers grabbed [Resident 1]'s arms and walked [him/her] over to a wall by the stairs. [Resident 1] was placed against the wall in a stabilization technique. Officer secured [Resident 1's] arm and [his/her] left leg against the wall. Once [Resident 1] was secured against the wall, Officers placed [him/her] in handcuffs, and both searched [Resident 1], resulting in no contraband being found. While stabilizing [Resident 1] against the wall, [Resident 1's] arms and legs were tense, and [s/he] would occasionally jerk [his/her] head in an attempt head butt Officers. [Resident 1] would make the comment that [s/he] "killed me" when [s/he] attempted to jerk [his/her] body or head in the officer's direction. [Resident 1] was placed in hobble restraints around both [his/her] legs to keep [him/her] from attempting to kick and head butt Officers. Officers escorted [Resident 1] to squad car and placed [him/her] in the rear of the squad. Officers transported [Resident 1] to the Washington	M 424		

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	0020994	A. BUILDING: _____ B. WING _____	03/31/2026

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M 424	Continued From page 7	M 424		

County Jail and spoke with Acute Care Services due to [Resident 1's] behavior. Acute Care Services advised [Resident 1] could be placed in jail with no further issues. It should be noted that [Resident 1] did not mention any thoughts of self-harm or suicide. On 12/25/2025, at approximately 2200 hours, [Resident 1] was turned over to jail without incident."
-Resident 1's incident reports stated the following:
"12/25/2025 at 8:30 PM: Incident Type: Assault, Clinical/Behavioral Change, Inappropriate Behavior, Threats/Intimidation. [Resident 1 became very aggressive verbally and physically towards staff and neighbors and law enforcement. [S/he] kicked glass door 4-5 times after being asked to come inside home. Police were called and [Resident 1] attached officers. [S/he] was detained at one point after kicking walls, fighting officers. [S/he] was removed from the home."
"01/23/2026 at 12:20 PM: Incident Type: Assault, Threats/Intimidation, Clinical/Behavioral Change, Inappropriate Behavior. [Resident 1] behavior problems because [s/he] couldn't find [his/her] lighter. [S/he] was cursing and hit a staff member. [S/he] broke cabinet and kicked door, staff tried to calm resident down. Police was called."

Resident 2
-Resident 2 was admitted to the provider's home on 01/12/2026 and was his/her own person. Resident 2's current ISP was dated for 01/20/2026. Resident 1's ISP stated the following:
"Behavioral Intervention: Any teaching or redirection required by the AFH provider? Please specify and attach BSP: Blank"
-Resident 2's behavior tracker stated the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020994	A. BUILDING: _____ B. WING _____	03/31/2026

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NEW LIFE ADULT FAMILY HOMES	1962 GREEN TREE RD WEST BEND, WI 53090

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M 424	Continued From page 8 "02/15/2026 at 3:10 PM, [Resident 2] became very upset after being told the tissue couldn't stay upstairs anymore because we are now monitoring toilet paper usage. [S/he] started yelling at staff asking why can't [s/he] use toilet paper. We told [him/her] 4 times that [s/he] can use the toilet paper it just can't stay upstairs. [S/he] then slammed the bathroom door and used paper towels and flushed them down the toilet. Target behavior: verbal aggression. Interventions used: verbal redirection and reinforce house rules." "02/27/2026, [Resident 2] was yelling, really loud at [his/her] voices. We asked [him/her] nicely to quiet down a bit. [S/he] said [s/he] pays $750 in rent, and can yell if [s/he] wants to. Target behavior: verbal aggression. Interventions used: verbal redirection." "03/01/2026, [Resident 2] has been yelling and talking to [him/herself]. [S/he] has made several remarks that [s/he] is going to kill [him/herself]. [S/he] also has yelled at staff most the day. Target behavior: verbal aggression/suicidal ideation. Interventions used: verbal redirection." On 03/31/2026 at approximately 10:40 AM, Surveyors interviewed Licensee A. Licensee A stated Resident 1 and Resident 2 have behaviors and law enforcement have been called multiple times to respond to their behaviors. Licensee A stated his/her landlord has let him/her know that if it continues s/he will need to move due to their behaviors disturbing the next door neighbors in the duplex. Licensee A stated Resident 1 and Resident 2 can become verbally aggressive and sometimes physical. Licensee A stated Resident 1 was arrested due to disorderly conduct with the police when they came. Licensee A stated s/he did not update Resident 1 and Resident 2's ISPs regarding their behaviors.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020994	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE ADULT FAMILY HOMES	1962 GREEN TREE RD 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 510	Continued From page 9	M 510		
M 510	88.09(1)(d)11 RESIDENT FUNDS Records maintained by the licensee of the resident's finances, including written authorization from the resident of resident's guardian to control the resident's funds. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure a record of funds was maintained for 1 of 1 resident (Resident 1) who the provider managed finances for. The provider assisted Resident 1 with his/her financial management, but did not keep a record of funds. Findings include: On 03/31/2026 at approximately 10:00 AM, Surveyors reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the facility on 11/24/2025. -Resident 1's Individual Service Plan (ISP) dated 11/25/2025, which was the most current ISP, stated Resident 1 is not allowed to manage his/her own personal finances and the Adult Family Home (AFH) will assist with personal funds. Resident 1 has a personal spending of $100 per month. On 03/31/2026 at approximately 11:00 AM, Surveyors interviewed Licensee A regarding Resident 1's personal funds. Licensee A stated s/he manages Resident 1's personal finances. Licensee A stated Resident 1 receives a monthly check for $100 and s/he will go cash the check for Resident 1 and give him/her money as s/he requests when s/he wants to purchase	M 510		

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	0020994	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 510	Continued From page 10 something. Licensee A stated Resident 1 usually spends all of his/her monthly allowance right away. On 03/31/2026, Surveyors requested to review Resident 1's monthly ledgers and receipts. Licensee A stated s/he only had a few receipts but did not keep a ledger or all of his/her receipts to identify what his/her money is being spent on monthly. Licensee A stated moving forward s/he will keep the receipts and document the information on a ledger.	M 510		
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 3 (Residents 1, 2 and 3) of 3 residents had physical and emotional privacy in living arrangements. A camera was observed inside the house by the living room pointing at the med cabinet, front door and living room couch.	M 550		

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	0020994	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 550	Continued From page 11 There was also a camera in the kitchen pointing at the backdoor and kitchen area. On 03/31/2026 at approximately 9:40 AM, Surveyors conducted a tour of the home. Surveyors observed two cameras in the facility. One camera was in the house by the living room pointing at the med cabinet, front door and living room couch. There was also a camera in the kitchen pointing at the backdoor and kitchen area. On 03/31/2026 at approximately 10:30 AM, Surveyors interviewed Licensee A. Licensee A stated s/he was not aware s/he could not have cameras in the home. Licensee A stated both cameras were only monitoring the doors of who was coming in and out. Surveyors had Licensee A show them the cameras and the recordings. The camera was not strictly on the door and picked up all audio. Licensee A acknowledged s/he could not have the cameras located there and took them down.	M 550		
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 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.	M 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020994	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE ADULT FAMILY HOMES	1962 GREEN TREE RD 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 12	M 556		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 2 of 2 residents were able to make decisions related to his/her smoking and food preferences. The licensee stated Resident 2 could not drink any dark liquids anywhere in the home except for at the dining room table and s/he could only smoke cigarettes from 7:00 AM-9:00 PM.

Findings include:

On 03/31/2026 at approximately 9:40 AM, Surveyors conducted a tour of the home. In the kitchen, Surveyors observed Resident 2 coming to the dining room table to drink his/her coffee.

On 03/31/2026 at approximately 9:45 AM, Surveyors interviewed Resident 2. Resident 2 stated s/he could not drink anywhere else in the house except for the dining room table. Resident 2 stated Licensee A told him/her since there is white carpet in the living room and s/he has spilled his/her coffee before that s/he is not allowed to drink dark liquids anywhere else in the house except for at the dining room table. Resident 2 stated s/he likes to smoke as well and s/he can only have cigarettes from 7:00 AM to 9:00 PM. Resident 2 stated s/he would like to smoke past 9:00 PM because s/he stays up later and s/he usually gets up around 5:30 AM and would like to smoke when s/he wakes up to but s/he is not allowed to.

On 03/31/2026 at approximately 11:30 AM, Surveyors interviewed Licensee A. Licensee A stated Resident 2 is independent with eating and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020994	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE ADULT FAMILY HOMES	1962 GREEN TREE RD 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 13 smoking and can make his/her needs known. Licensee A stated Resident 2 can be clumsy sometimes and will spill his/her drinks in the living room so s/he suggested that unless s/he has a cup with a lid on it, then s/he has to drink his/her drinks at the dining room table. Licensee A also stated the smoking hours are from 7:00 AM to 9:00 PM. Licensee A stated s/he is staffed 24/7 so there is not a specific reason why Resident 2 can't smoke outside those parameters.	M 556		