STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019640	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA 2	112 EMMA COURT MADISON, WI 53716

(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 09/03/2025, Surveyor conducted a standard survey at Emma 2, an AFH in Madison. Four deficiencies were identified. Census: 3	M 000		
M 298	88.05(3)(g) WINDOWS AND VENTILATION The home shall have ventilation for health and comfort. There shall be at least one window which is capable of being opened to the outside in each resident sleeping room and each common room used by residents. Windows used for ventilation shall be screened during appropriate seasons of the year. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 3 sleeping rooms had a screen in the window to allow for ventilation. Resident 1's room did not have a screen for ventilation. Findings include: On 09/03/2025 at approximately 11:00 a.m., Surveyor toured the provider's home. Surveyor observed Resident 1's bedroom window was open with no screen installed in the window. On 09/03/2025 at approximately 11:20 a.m., Surveyor reviewed concern with Licensee A and Assistant Manager B that Resident 1's window did not have a screen installed. Licensee A, who was out of town and participated in the survey via phone, stated s/he thought Resident 1's room	M 298		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019640	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA 2	112 EMMA COURT MADISON, WI 53716

(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 298	Continued From page 1 had a screen.	M 298		
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 2 of 3 individual service plans (ISP) reviewed were updated at least once every 6 months and when there was a substantial change in resident needs or preferences. Resident 2's ISP did not address Ozempic administration by family, was not signed by Resident 2's guardian and had not been updated in greater than 6 months. Resident 1's ISP did not include his/her current supervision requirements or the need for	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019640	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA 2	112 EMMA COURT MADISON, WI 53716

(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 2 Resident 1's personal items to be stored outside his/her room and had not been reviewed in greater than 6 months. Findings include: On 09/03/2025 at 10:30 a.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 2: Resident 2 admitted to the provider's home on 09/03/2024 with diagnoses including intellectual disability, mood disorder, conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, intermittent explosive disorder, anxiety, depression and autism. Resident 2 had a legal guardian. Resident 2's physician orders included Ozempic 2 mg/3 ml (Start Date: 06/27/2025) - Inject .5 mg weekly. Resident 2's medication administration record (MAR), dated 08/01/2025 to 09/02/2025, did not document weekly administration of the Ozempic. Resident 2's ISP, dated 01/07/2025, documented the provider assisted with medication administration. Resident 2's ISP was not signed by his/her legal guardian and had not been updated in greater than 6 months. Resident 2's record also included a behavioral support plan (BSP), dated 12/03/2024. On 09/03/2025 at approximately 11:20 a.m., Surveyor interviewed Licensee A and Assistant Manager B. While discussing medications, Assistant Manager B stated Resident 2's family member administered the Ozempic. Surveyor shared concern with Licensee A and Assistant Manager B that Resident 2's ISP did not address the Ozempic administration by family, was not	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019640	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA 2	112 EMMA COURT MADISON, WI 53716

(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 3	M 424		

signed by Resident 2's guardian and had not been updated in greater than 6 months. Licensee A acknowledged Surveyor's concern and stated there was a review coming up with Resident 2's team.

Example 2 - Resident 1:

Resident 1 admitted to the provider's home on 03/01/2024 with diagnoses including autism, seizure disorder and impulse control. Resident 1's ISP was dated 01/10/2025. The ISP documented Resident 1 required 24 hour supervision. Resident 1's record included a behavioral support plan (BSP), dated 07/09/2025, that documented Resident 1 required 2:1 staffing for 16 hours/day and 1:1 staffing during the overnight hours.

On 09/03/2025 at approximately 11:00 a.m., Surveyor toured the provider's home and observed Resident 1's personal items were stored in the unoccupied bedroom next door. Assistant Manager B stated Resident 1's items were stored next door for Resident 1's safety because Resident 1 liked to throw items.

On 09/03/2025 at approximately 11:20 a.m., Surveyor interviewed Licensee A and Assistant Manager B. While discussing Resident 1's supervision requirements Licensee A stated Resident 1 now required 2:1 staffing for 12 hours/day and 1:1 staffing for the remaining 12 hours/day. Surveyor shared concern that neither the ISP, nor the BSP were updated to reflect the current supervision requirements or the need for Resident 1's items to be stored outside Resident 1's room. Surveyor also shared concern that the ISP had not been reviewed in greater than 6 months. Licensee A acknowledged Surveyor's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019640	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA 2	112 EMMA COURT MADISON, WI 53716

(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 4 concern and stated s/he had a review of the ISP scheduled with Resident 1's team later in the week. On 09/03/2025 at 4:45 p.m., Surveyor received documentation from Licensee A that indicated Resident 1's staffing requirement changed to 2:1 staffing for 12 hours/day and 1:1 staffing for the remaining 12 hours/day on 08/01/2025.	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, and interview, the provider did not arrange for the provision of individualized services identified in the individual service plan (ISP). Resident 1 did not have 2:1 staffing as required upon Surveyor's arrival to the facility. Findings include: On 09/03/2025 at 9:30 a.m., Surveyor arrived to the provider's home. Surveyor observed Caregiver C was the only caregiver present in the home. Resident 1 was present in the living room with Caregiver C. Caregiver C confirmed s/he was the only caregiver present. Caregiver C stated Caregiver D had gone to the affiliated adult family home next door and the other caregiver	M 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019640	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA 2	112 EMMA COURT MADISON, WI 53716

(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 436	Continued From page 5 was at the grocery store with the other residents. On 09/03/2025 at approximately 9:40 a.m., Caregiver D entered the home. On 09/03/2025 at 10:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 admitted to the provider's home on 03/01/2024 with diagnoses including autism, seizure disorder and impulse control. Resident 1's record included a behavioral support plan (BSP), dated 07/09/2025, that documented Resident 1 required 2:1 staffing for 16 hours/day and 1:1 staffing during the overnight hours. On 09/03/2025 at approximately 11:20 a.m., Surveyor interviewed Licensee A and Assistant Manager B and shared concern that the home had only 1 caregiver present upon Surveyor's arrival when Resident 1, who required 2:1 staffing, was present in the home. Licensee A stated s/he was surprised to hear Surveyor's concern because Caregiver D was scheduled to work at the home and should have been present in the home rather than the affiliated home next door.	M 436		
M 540	88.09(2)(c) Location and Retention Period Location and retention period. Service provider and licensee records shall be available at the adult family home for review by the licensing agency. A service provider's record shall be available while the service provider is employed by the home and for at least 3 years after ending employment.	M 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019640	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA 2	112 EMMA COURT MADISON, WI 53716

(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 540	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the record of 1 of 3 caregivers reviewed was available for review. The provider did not have documentation of Caregiver C's background check completed upon hire. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), a complete Caregiver Background Check, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A Governmental Findings Report from DHS that reports the person's status, including administrative finding or licensing restrictions (IBIS). On 09/03/2025 at 9:45 a.m., Surveyor reviewed employee records. The employee record of Caregiver C documented that s/he was hired in January 2025. Caregiver C's record included a BID, dated 07/26/2025, a DOJ, dated 07/27/2025, and an IBIS, dated 07/27/2025. On 09/03/2025 at approximately 11:20 a.m., Surveyor reviewed concern with Licensee A and Assistant Manager B that Caregiver C's record did not contain a BID completed upon hire or a DOJ and IBIS completed within 60 days of hire. Licensee A stated s/he had completed the BID, DOJ and IBIS upon hire, but hadn't printed the DOJ and IBIS to have the documents on file. On 09/03/2025 at 4:45 p.m., Surveyor received	M 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019640	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA 2	112 EMMA COURT MADISON, WI 53716

(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 540	Continued From page 7 documentation of a BID completed by Caregiver C on 12/22/2024. Surveyor did not receive documentation of a DOJ and IBIS completed within 60 days of hire.	M 540		