STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 10/17/2024, with additional information gathered through 12/09/2024, Surveyors conducted a complaint investigation at Just 4 Me Adult Family Home. As a result, 15 deficiencies were identified and 2 of 2 complaints were substantiated. Census: 1	M 000		
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure that s/he or a service provider was awake at all times to monitor Resident 2 who was assessed to need 24/7 supervision. Resident 2 was assessed by facility staff to be "monitored closely" due to "high elopement risk" and the desire to call 911 frequently. In addition, an outside provider also assessed Resident 2 to need 24/7 supervision. Licensee B and Residential Director A indicated they did not provide 24/7 supervision at all times, as they would sleep either in bedroom located downstairs or in bedroom located down the hall from Resident 2. Findings Include:	M 218		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 218	Continued From page 1 On 09/16/2024 and 10/15/2024, the department received complaints regarding supervision. The adult family home is licensed to care for up to 3 adults who are developmentally disabled. A review of the home's program statement indicates, "Residents have 24-hour access to services in their homes. The service is for people who: are older adults diagnosed with a development disability; cannot live independently without support services; require 24-hour supervision or care. Supportive housing benefits are provided by a trained care provider and include: a private or shared room; a Supportive Housing Coordinator to help residents arrange for services; access to support services 24 hours a day, as needed; case management and support services. Support services include: personal care services (assistance with ADLs); 24 hour supervision; housekeeping and laundry; grocery shopping; meals; transportation; social activities; medication reminders and assistance." Per Wisconsin Administrative Code 88.02(9) the definition of Continous Care means: "the need for supervision, intervention or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night. Note: Examples of persons who need continuous care are wanderers, persons with irreversible dementia, persons who are self abusive or who become agitated or emotionally upset and persons whose changing or unstable health condition requires monitoring." On 10/17/2024, Surveyors conducted an onsite visit to the home. Surveyors met with Residential Director A (in person) and Licensee B (via	M 218		

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 218	Continued From page 2	M 218		

phone). Residential Director A indicated Resident 2 no longer resides at the home. Surveyor requested Resident 2's resident record.

Resident 2 was admitted to the facility on 05/25/2024 with diagnoses to include William's Syndrome (genetic disorder) and hypochondria. Resident 2's record reflected Resident 2 was under court appointed guardianship, with Guardian C named as guardian. Resident 2 discharged from the home on 09/11/2024.

On 10/17/2024 at 10:15 AM, Surveyor interviewed Residential Director A. Residential Director A stated s/he started at the end of May, the day before Resident 2 was admitted. Residential Director A is the primary caregiver, but does have Service Provider D available during times when Residential Director A needs a break. Residential Director A stated Licensee B lived in the home until July and then moved out along with his/her family members. Residential Director A stated, "That's why I came in, because someone needed to be with [Resident 2]." Residential Director A stated, "Someone is here 24/7." Residential Director A stated s/he does not "live" in the home but does sleep in the home when working at it. Residential Director A stated Resident 2 was independent with walking and s/he would try to run or take off frequently. Residential Director A stated in the beginning, Resident 2 was doing good but then starting in July s/he had an increase in behaviors. Resident 2 would try to call 911 frequently, jump out of moving vehicles, and walk into others personal space. Residential Director A gave an example of a time Resident 2 and Residential Director A were at a coffee shop and Resident 2 took Residential Director A's phone and ran off. Residential Director A stated Resident 2 would leave the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 218	Continued From page 3	M 218		

home on his/her own and is not safe to go out by self. Residential Director A stated, "[Resident 2] would try to walk off by self, anywhere [s/he] would walk off." Residential Director A gave another example of a time Residential Director A was sleeping and Resident 2 put his/her hand under Residential Director A's pillow to get his/her phone. Residential Director A stated s/he woke up to Resident 2 standing over him/her. Residential Director A stated during these times, Resident 2 required 1:1 supervision so Residential Director A would sleep upstairs in the "staff room" located at the opposite end of the hallway of Resident 2's bedroom.

On 10/17/2024 at approximately 11:15 AM, Surveyor toured the home with Residential Director A. Surveyor noted the bedroom Resident 2 occupied contained a large bathtub. Residential Director A stated s/he was concerned with Resident 2 staying in this room because Resident 2 had attempted to commit suicide a year or so ago by drowning in a bathtub. Residential Director A stated during times when Resident 2 was having an increase in behaviors, Residential Director A would sleep upstairs in the "staff room" to monitor Resident 2. Surveyor observed the "staff room" at the other end of the hallway. Surveyor observed a bed that was located to the right of the doorway, with the head of the bed at the far right corner, not in eyesight of Resident 2's bedroom. Residential Director A stated when Resident 2 had an increase in behaviors and be verbally loud and crying, s/he felt Resident 2 needed someone to be with him/her. Residential Director A stated once Resident 2 went to sleep in his/her room, that is when Residential Director A would sleep upstairs in the staff bedroom. Surveyor requested Resident 2's level of supervision assessment from Residential Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 218	Continued From page 4 A. Residential Director A indicated Licensee B would have that information. While onsite, Surveyor reviewed Resident 2's Log. The following was noted: -07/17 "Very rough day for "Resident 2]. [Resident 2] continued to enter the staff room during the night, as well as putting [his/her] ears to all other doors saying [s/he] hears someone snoring inside." -07/21 "[Resident 2] refused to go to church. [Resident 2] tried to get out of the car repeat[sic] as well as refusing to keep seat belt on and kicking me while I sat in the back with [him/her]. A PRN [as needed] was needed." -07/27"[Resident 2] did attend a birthday party... [Resident 2] wanted to wander off and not listen to any redirecting authority." -08/04 "Took a walk to lake, [Resident 2] was not happy and continued to try walking off from the crowd and asking passer byers to call 911 for [him/her]. -08/19 "It was a very hetic[sic] morning. [Resident 2] has thrown tantrums the entire morning trying to get out of going to day services...Day services didn't go to well for the first day. [Resident 2] kept wandering off, going through residents purses and not listening to staff." -08/26 "Again I woke up to [Resident 2] standing over me looking for my phone saying [his/her] head hurts and [s/he] needed a ambulance" -09/01 "[Resident 2] has completely destroyed [his/her] T.V. and now is unable to use it. [Resident 2] was up at 3a.m. at the living quarters door trying to push it down which is now loose. After a hr[hour] [s/he] did return to [his/her] room..." -09/08 "Not a good morning [Resident 2] was very upset about not making it to church with [his/her] mom. [S/he] screamed all morning and would not	M 218		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 218	Continued From page 5	M 218		

stop walking up to me in my personal space and refuse to back up. [S/he] eventually went to [his/her] room but continued to yell out about needing a ambulance."

On 10/17/2024 at 2:33 PM, Surveyor sent an email to Licensee B requesting Resident 2's ISP (Individualized Service Plan) and "all assessments completed" by the home related to Resident 2.

On 10/18/2024 at 11:08 AM, Surveyor received an email containing "A Resident Health Assessment" dated 05/27/2024 for Resident 2. The assessment indicated Resident 2 is independent with ambulation. Resident 2 is a "High" Elopement Risk and staff should "Monitor Closely" as Resident 2 "will attempt to call 911." The assessment also indicated Resident 2 has "Periods of harm to others, shared suicide attempt last year...Aggression towards other residents, disclosed pornography addiction...psychiatric care required as need[sic]."

Licensee B also attached Resident 2's BSP (Behavior Support Plan). The document stated the following:
"Recommendations:
1. Proactive strategies: These are strategies to use before the problem behavior occurs and to establish situations where positive and appropriate behavioral responses are more likely to occur.
a. Forewarning of changes in Schedule or routine: Giving [Resident 2] a warning 5-10 minutes before a change is to occur in [his/her] schedule will help prepare [him/her] for the transition. This can also be done in the form a visual/printed agenda of the day's activities.
b. Behavior momentum: Using behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 218	Continued From page 6	M 218		

momentum techniques can be very helpful in establishing and i maintaining positive behavioral responses. Presenting easier tasks to [Resident 2] before asking [him/her] to do something more difficult will allow [him/her] to access reinforcement for the performance on the easier task, making it more likely that [s/he] will respond positively to the more difficult task next.

c. Reinforce appropriate behavior: When [Resident 2] is engaging in appropriate behaviors, especially those that are directly incompatible with the problem behaviors, [s/he] should be reinforced immediately. [His/her] current preferred items or activities include listening to music, using his Kindle, and playing video games.

2. Reactive strategies: These are strategies to use in response to the problem behavior after they have occurred in an attempt to minimize the episode and return [not Resident 2's name] to a neutral state.

a. Block and ignore.' When [Resident 2] engages in physical aggression or throwing objects, staff should not verbally attend to [him/her]. Instead, they should block themselves or other from potential harm while [Resident 2] is exhibiting the problem behavior. If [s/he] becomes a danger to [him/herself] or others staff should employ the safety procedure techniques in which they are trained

b. Redirection: When [Resident 2] engages in verbally aggressive behavior, stat [sic] should use verbal redirecti an [sic] techniques that they are currently using to de-escalate the behavior. The se [sic] strategies can include presenting [him/her] with options and reminding hirr[sic] when [s/he] can have access to whatever it is [s/he] is requesting.

3. Behavioral data should be maintained on all of the above-mentioned behavioTs[sic] and can be done on the attached Behav ior[sic] Checklist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 218	Continued From page 7	M 218		

By utilizing this data collection, a continuous functional assessment af[sic] [his/her] behavior can be conducted and [his/her] Behavior Support Plan can more easily be r viewed[sic] and changed if necessary. Decisions on behavioral programming should ñ ways be based on the current data so that staff can ensure the interventions are appro iriate[sic].
4. Follow-up support and staff trainii g[sic] by a Board Certified Behavior Analyst should occur on a regular basis as determ ned[sic] and agyeed[sic] upon by the analyst and the agency

If there are any questions regarding these rect mmendations[sic]. please do not hesitate to contact me.

[Behavior Analyst Director H]
Date
12-30-12"

Surveyor note: The BSP document does not address Resident 2's level of supervision or wandering or exit seeking behaviors.

On 10/21/2024 at 9:00 AM, Surveyor interviewed IRIS Consultant F. IRIS Consultant F verified Resident 2 is an IRIS member and is receiving funding through the IRIS program. IRIS Consultant F stated Resident 2 moved from another county to reside at the AFH on 05/25/2024. IRIS Consultant F stated s/he became the consultant after Resident 2 moved to the AFH. IRIS Consultant F stated s/he reached out to Licensee B in June or July requesting a copy of Resident 2's ISP and BSP. Licensee B provided Resident 2's ISP from his/her previous home and the same BSP Licensee B provided to Surveyor (noted above). IRIS Consultant F stated IRIS assessments/screens from previous months

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 218	Continued From page 8	M 218		

indicated Resident 2 required "constant supervision" due to significant anxiety and wanting to call 911. IRIS Consultant F stated Resident 2 required 24/7 awake staff especially at the rate IRIS was paying for Resident 2's care at the AFH. Surveyor requested a copy of IRIS' most recent BSP for Resident 2.

Surveyor reviewed Resident 2's IRIS' BSP dated 05/16/2024. The following was noted:
- "[Resident 2] does exhibit wandering behaviors throughout the day. [S/He] will attempt to leave and go to the hospital due to hypochondria and anxiety even after being told [s/he] is ok, does not need medical treatment, and there is no immediate concern. [Resident 2] is monitored with staff both at the AFH and day program to prevent [him/her] from eloping and there are alarms on the doors at the home as well. When in the community [Resident 2] has to have additional supervision as [s/he] will wander off and find random strangers and ask them for their phone or bring [him/her] to the hospital.
-How often do caregivers need to provide intervention specific to the behavior/risk (i.e. 4x/day, 2x/week)? Several times per day, supervision is 24/7 due to risk
-What things are effective in preventing, redirecting and/or supporting this behavior/risk? All phones must be kept in sight or out of reach of [Resident 2] at all times. [S/He] will try to take phones of anyone around [him/her] if [s/he] has access. Redirect, 24/7 supervision to ensure that [s/he] is not calling 911. Talk through the situation, remind [him/her] of techniques taught to [him/her] by therapist (in process)
-[Resident 2] does exhibit offensive/violent behaviors towards others. [S/He] requires constant supervision as [s/he] struggles to get along with others. [Resident 2] will push [his/her]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 218	Continued From page 9	M 218		

housemates, get in their business, and will kick/throw items in the home when upset or angry. [S/He] has significant anxiety and hypochondria and needs a controlled environment and maintaining a schedule. [Resident 2] is easily upset/anxious which in turn causes [him/her] to frequently dial 911 and steal other peoples phones in order to have 911 come to [his/her] location. [S/He] will also try to sneak off and try to seek medical treatment as well. [Resident 2] is with staff at all times and is monitored to ensure [s/he] not harming others or damaging items. [S/He] is constantly redirected throughout the day and given activities to do as well.
-How often do caregivers need to provide intervention specific to the behavior/risk (i.e. 4x/day, 2x/week)? Frequently throughout the day"

On 10/30/2024 at approximately 1:00 PM, Surveyor interviewed Licensee B and Residential Director A. Licensee B stated s/he did not have any contact with the previous AFH setting for Resident 2. Licensee B stated the previous AFH setting was unwilling to provide any information to Licensee B. Licensee B stated s/he was living there until July or August. Licensee B stated s/he had hired Residential Director A to take over caregiving when Licensee B left the home. Licensee B stated Residential Director A resides there now. Licensee B stated Resident 2 required 24 hour supervision at times. Residential Director A stated when Resident 2 was having escalated behaviors that is when it was needed. Licensee B stated s/he wasn't always 1:1. Licensee B stated, "As you saw, there is a staff bedroom upstairs...I slept there when needed and [Residential Director A] slept up there when needed." Licensee B stated they were provided more than enough supervision based on the staffing ratios

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 218	Continued From page 10	M 218		

set forth in the regulations. Surveyor reminded Licensee B the State of Wisconsin Adult Family Home regulations do not provide a ratio but rather the staffing levels are based on resident needs. Licensee B stated, "We assess based on [his/her] needs, which fluctuated." Licensee B stated Resident 2's psychiatrist shared when s/he was getting to the point where s/he potentially needed 1:1 care. Licensee B stated they were having discussions with the advisory board that maybe the AFH setting wasn't appropriate setting. Licensee B stated Service Provider D came in maybe the last two weeks that Resident 2 resided there and s/he was just at night due to escalated behaviors. Service Provider D was able to give Residential Director A a break to go spend time with his/her family.

On 11/21/2024 at approximately 2:00 PM, Surveyor discussed this case with Detective G of the local police department. Detective G had indicated s/he has wrapped up their investigation and would forward the police report to Surveyor.

On 12/09/2024, Surveyor received Detective G's police report. The following is noted from the report:

*On 11/11/2024, Detective G interviewed Residential Director A's family member. Family Member I reported to Detective G, Residential Director A would sleep in the bedroom on the first floor or sometimes in the bedroom on the second floor by Resident 2. Family Member I indicated Service Provider D worked at the home as well and said Service Provider D volunteered and worked there twice. Family Member I said once Licensee B left, Residential Director A works at the group home every day and every night.

*On 11/12/2024, Detective G interviewed another family member of Residential Director A.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 218	Continued From page 11 Family Member J stated, Residential Director A basically lives at the group home and spends every night there. *On 11/14/2024, Detective G interviewed another family member of Residential Director A. Family Member K indicated Residential Director A is at the group home 24 hours a day and is the only one that took care of Resident 2. In summary, Resident 2 was assessed by the home to be monitored closely due to high elopement risk. In addition, outside service providers indicated Resident 2 required 24/7 supervision due to wandering and physical, aggressive behaviors towards others. Licensee B did not develop an ISP or BSP to address the need for the level of supervision Resident 2 required. Licensee B and Residential Director A did not provide continuous 24/7 supervision to Resident 2 per the assessments, Licensee B and Residential Director A indicated they would sleep while Resident 2 slept. Cross Reference M0410 88.06(3)(d) Individual Service Plan	M 218		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on record review and interview, the	M 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 230	Continued From page 12	M 230		

licensee permitted the existence or continuation of a condition in the home which places the health, safety and welfare of a resident at substantial risk of harm.

Resident 2 alleged Residential Director A and family members physically abused Resident 2. Licensee B was made aware of the allegations and did not conduct a formal investigation or report the allegations to the Department. Additionally, Licensee B continued to allow Residential Director A and family members to work and live at the facility.

Findings Include:

On 09/16/2024 and 10/15/2024, the department received complaints regarding allegations of physical abuse.

On 10/17/2024, Surveyors conducted an onsite visit to the home. Surveyors met with Residential Director A (in person) and Licensee B (via phone). Residential Director A verified there is currently 1 resident living at the home, Resident 1, who was admitted on 10/10/2024. Residential Director A indicated Resident 2 no longer resides at the home. Surveyor requested Resident 2's resident record and any investigation into abuse allegations Resident 2 had made.

Resident 2 was admitted to the facility on 05/25/2024 with diagnoses to include William's Syndrome (genetic disorder) and hypochondria. Resident 2 discharged from the home on 09/11/2024. Resident 2's record reflected Resident 2 was under court appointed guardianship, with Guardian C named as guardian. Resident 2 discharged from the facility on 09/11/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 230	Continued From page 13 On 10/17/2024 at 10:15 AM, Surveyor interviewed Residential Director A. Residential Director A indicated s/he has a 17 year old, 15 year old, 14 year old and 8 year old who do come to the home and interact with residents such as watch T.V., play games, make food or help with taking medications to residents but never distributing them to the residents. Residential Director A indicated the children do not live in the home, as Residential Director A has a home just about a block away from the adult family home. Residential Director A stated Guardian C and/or Resident 2 never complained of anything. Surveyor requested to review Resident 2's resident record. On 10/17/2024 at 10:25 AM, Surveyor received an email from Licensee B. Licensee B attached a document titled, "[Resident 2's initials] Notes 3" with no date to the email which contained the following statement: "On October 10, 2024 at 10:21am CST, I returned a call to Manitowoc Police Department [Detective] regarding a complaint made by [Guardian C]; we spoke for 48 minutes. The Detective could not share specifics regarding the complaint; [s/he] advised I would need to contact the records department to receive a copy. Upon request and questions, I shared the following with the Detective: a. Just 4 Me Adult Family Home (J4M) is a Wisconsin licensed facility. b. J4M's Residential Director in collaboration with staff supervises residents. c. [Guardian C] contacted the owner, [Licensee B], regarding admission for [Resident 2]. d. [Guardian C] expressed concerns with [his/her] previous provider, not having food, gambling, domestic violence in the home etc. e. [Guardian C] medicates [Resident 2] with CBD	M 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

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M 230	Continued From page 14	M 230		

gummies when in [his/her] care and [s/he] become[sic] "uncontrollable;" the RD [Residential Director] expressed [s/he] appeared inebriated when [s/he] would during his pick-up/drop-off.[sic]
f. Initially, [Resident 2] was able to socialize with AFM teenage volunteers, however, it became apparent that this was not appropriate due to [his/her] pornography addiction and communicating with underage [persons]. [S/he] would become increasingly agitated with the visits would end and make false statements due to [his/her] anger.
g. On top of [his/her] prescribed meds, [Guardian C] would direct staff to give [him/her] numerous vitamin supplements.
h. [Resident 2's] behavior escalated to being combative towards staff; these incidents were more frequent after visits with [Guardian C]. J4M's psychologists assisted Licensee B in the development of a behavior plan. Also, discussions were held with J4M's [Advisory Board President E] regarding [Resident 2's] violence towards staff and [Guardian C's] refusal to follow J4M's policy. A verbal warning was given to [Resident 2] and a written communication was sent to [Guardian C] after [Resident 2] kicked the RD during a medical visit and [his/her] doctor had to intervene. In addition, [his/her] psychiatrist noted the AFH model may no longer be a good fit due to intensified behaviors. Prior to [Guardian C] terminating [his/her] placement [s/he] discharged from attending the ADH in less than a week to [his/her] uncontrollable behaviors.
i. The Detective noted [s/he] had been advised by polices [sic] officers that [Resident 2] had made 911 calls; [s/he] was made award that this took place at [his/her] previous AFH; charges were pressed and [s/he] was required to pay a fine.
j. During [Guardian C's] pick-up, [Resident 2] would become combative and would express

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 230	Continued From page 15	M 230		

[s/he] did not want to go; [Guardian C] would often-times force [him/her] and would then call to drop [him/her] off early. [S/he] admitted to being a trigger for [him/her] on numerous occasions and was aware it would take a min [minimum] of 2 weeks after a visit for [his/her] behaviors to decrease.
k. [Guardian C], refused to communicate with the RD; [s/he] would often express [his/her] political view with the RD, making negative statements regarding [a political candidate] the RD felt [his/her] comments and oftentimes behaviors were [inappropriate].
l. Initially, [Guardian C] would not follow the visitation guideline; [s/he] appeared to want to befriend [Licensee B]. It was shared that [s/he] became obsessed with [his/her] whereabouts.
m. [Guardian C] never reported any concerns of abuse and/nor neglect, outside of [him/her] not wanting [his/her] nails clipped; [Guardian C] later advised [s/he] was aware that [s/he] did not want anyone "messing with [him/her]."
n. [Guardian C] had advised and reasserted when [s/he] terminated [Resident 2's] placement that [s/he] lies and this was all "[his/her] fault" as [s/he] made the same assertions at [his/her] previous placement and they were found to be false.
o. [Guardian C] has sent inappropriate texts to the RD and Licensee B. After terminating [Resident 2's] placement, [S/he] was advised to only communicate with [Licensee B] via email which [s/he] then subsequently blocked [his/her].
*[Resident 2] advised the RD and staff that [Guardian C] got into a physical altercation with the owner of [his/her] previous AFH. [S/He] stated [Guardian C] did not visit [him/her] there regularly.
I made a follow-up call to the Detective on October 10, 2024, at 11:43 am CST and left a VM advising to contact me, [Licensee B], or the Advisory Board President, [Advisory Board

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	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 230	Continued From page 16	M 230		

President E] for any follow-up questions." The document was signed by Licensee B.

On 10/17/2024 at 10:35 AM, Surveyor reviewed Resident 2's daily progress notes. A note written by Residential Director A dated 09/11/2024 stated, "[Guardian C] came to pick up [Resident 2] and [s/he] says [s/he] will not be back due to lack of care and also acussed [sic] my family of harming [him/her]..."

On 10/17/2024 at approximately 1:30 PM, Surveyor received the following note via email from Licensee B. "[Guardian C] never reported any concerns of abuse and/nor neglect..."

On 10/18/2024 at 11:08 AM, Licensee B stated the following via email, "Outside of outlandish statements (ex. a petite/2 foot 8-year-old "whooping [Resident 2]" with a belt) made by [Guardian C] on the day [s/he] abruptly terminated [his/her] placement, I have not received notifications of any specific complaints. It has all felt like a "fishing expedition" which unfortunately, is not surprising based on attempts to weaponize the police, utilize intimidation strategies etc."

On 10/21/2024 at 3:20 PM, Surveyor interviewed Guardian C. Guardian C stated on 09/10/2024 Resident 2 informed of him/her that Residential Director A whipped Resident 2 with a belt once, Residential Director A's 17 year old son also whipped Resident 2 once with a belt and Residential Director A's 14 year old did so more than once. Resident 2 indicated to Guardian C it had been going on for several months but was afraid to tell Guardian C because it would get worse. Guardian C stated s/he asked Resident 2 multiple times if s/he was telling the truth and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 230	Continued From page 17 Resident 2 confirmed s/he was telling the truth. Guardian C stated s/he contacted Adult Protective Services (APS) to inform them of the concerns. Guardian C stated s/he confronted Residential Director A on 09/11/2024 about the accusations. Guardian C stated Residential Director A denied the accusations. Guardian C stated s/he also let Licensee B know about the accusations and Licensee B directed him/her to bring them to Residential Director A. Guardian C stated, "That's stupid to go back to [Residential Director A] because [s/he] is the only person working there and the accusations are against [him/her]." On 10/23/2024, the Department received the APS report. The Surveyor noted the following: -On 09/11/2024, APS received a referral regarding abuse allegations involving Resident 2 and Residential Director A and his/her family members. -On 09/12/2024, APS worker and a police officer met with Resident 2 and Guardian C at Guardian C's home to gather information. -On 09/27/2024, APS worker and police officer attended the forensic interview conducted with Resident 2 regarding the allegations of abuse. *Resident 2 stated Residential Director A's children "whipped [him/her] with a belt" and punched Resident 2 in the stomach and ribs "a bunch of times." In addition, Resident 2 indicated one of the children "choked" him/her and threw Resident 2 across the bed. Resident 2 stated that Residential Director A was in his/her room when the children would do these things to him/her. Resident 2 indicated that s/he told Residential Director A about these occurrences but "[s/he] didn't believe me." Resident 2 also stated that Residential Director A also used a belt on him/her and cussed at him/her.	M 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

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JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 230	Continued From page 18	M 230		

-On 10/15/2024, APS worker and Detective notified Licensee B and Residential Director A about an abuse referral to APS related to Resident 2.

On 10/30/2024 at approximately 1:00 PM, Surveyor interviewed Licensee B and Residential Director A. Licensee B stated s/he did not hear about any abuse allegations until the police informed him/her. Surveyor reviewed the 09/11/2024 progress note related to the reasons Guardian C removed Resident 2 from the home. Residential Director A then indicated Guardian C let him/her know about the abuse allegations at the time of removing Resident 2 from the home. Residential Director A stated Guardian C came and got Resident 2 and said they were going for lunch. They had lunch and came back and grabbed all Resident 2's belongings and Guardian C stated s/he didn't like the way Resident 2 was being treated here. Residential Director A stated that s/he informed Guardian C that if s/he was taking Resident 2, s/he needed to give a 30 day written notice. Guardian C told Residential Director A that s/he was going to call Licensee B and after talking with Licensee B, s/he would bring Resident 2 back to the home. Residential Director A stated Guardian C called later in the day and said s/he was not bringing Resident 2 back and she asked for his things. Residential Director A stated, "Guardian C said my children were abusing [Resident 2]." Residential Director A stated, "Guardian C accused my 8 year old [child] of whipping Resident 2 with a belt. My [child] doesn't wear a belt." Residential Director A stated Guardian C asked where Resident 2 got the scrape on his/her knee from. Residential Director A explained to Guardian C that it was from Resident 2 carrying a tv down the stairs. Residential Director A stated

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	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 230	Continued From page 19	M 230		

that at that time, s/he asked Resident 2 if they were bad or mean to him/her. Resident 2 told him/her "no." Guardian C then dragged him/her out to the car. Guardian C wouldn't let Resident 2 talk. Residential Director A stated s/he would have brought my kids out to talk and figure this all out. Residential Director A then indicated Guardian C sent messages to him/her about my kids abusing Resident 2. Residential Director A stated s/he notified Licensee B right away. Licensee B stated, "[Residential Director A] told me about the allegations...You should see [his/her] [daughter/son], the 8 year old, [s/he's] slim with suspenders. Licensee B stated s/he reached out to APS (Adult Protective Services) and APS got involved, "because I requested it." Licensee B stated, "I did investigate. I spoke with [Residential Director A]. I did not talk to [Resident 2] and I did not involve the children. I know the law is specific about reporting abuse. This was not that. I asked [him/her] to please if there is a question or concern to follow the protocol and talk to [Residential Director A]. I can provide you with a note on that (the investigation) too. I looked at the pattern of what preceded it. I did not have access to [Resident 2] because [s/he] was gone. I wasn't going to state anything to [his/her] 8 year old [son/daughter], because they hadn't been around in months, because of [Resident 2's] behaviors and it was not a good fit. I will resend my last note along with my advisory board who goes through the key points with Resident 2. I sent you a checklist that I used to document everything. It has a number of things. If you need more, I can give you that. Surveyor confirmed the document titled "[Resident 2's initials] Notes 3" Surveyor received on 10/17/2024 was what Licensee B was referencing. Licensee B stated, "That is my investigation. It is a breakdown of everything that transpired...That's a

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	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 230	Continued From page 20 synopsis of everything." In conclusion, Licensee B's investigation did not include interviews with Resident 2, Residential Director A or family members of Residential Director A, and Guardian C to get specific facts of when the incidents happened, what happened or who was involved. Additionally, Licensee B's investigation did not include a summary of what happened or a conclusion to the investigation. Licensee B also did not ensure the safety of all residents as s/he allowed Residential Director A to continue to work and provide services to other residents at the home until the investigation had been concluded. Cross Reference: Z0005 50.065(2)(b) Entity Background Check Requirements Z0055 13.05(3)(a) Entity Allegation Reporting Requirement	M 230		
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.	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 232	Continued From page 21 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 (Residential Director A and Service Provider D) service providers reviewed had a communicable disease screen, including tuberculosis (TB) test, completed within 90 days before the start of providing service. Residential Director A was hired on 01/30/2024. Residential Director A's employee record contained a TB test from 04/01/2022 and no communicable disease screen. Service Provider D was hired on 08/30/2024. Service Provider D's employee record did not contain a TB test or communicable disease screen. Findings include: On 09/16/2024 and 10/15/2024, the Department received a complaint alleging abuse, medication and environmental concerns in the home. On 10/17/2024 at 10:05 AM, Surveyors met with Residential Director A upon arrival to the home. Director A verified s/he and Service Provider D are the only employees in the home and they do not have a set schedule. S/he reported Service Provider D helps out when needed otherwise Residentital Director A is at the home the majority of the time. Residential Director A stated Licensee B is on call and fills in as needed as well. Residential Director A confirmed s/he does not have access to staff records and Surveyors would need to request records from Licensee B. Director A stated s/he started working in the home towards the end of May and Service Provider D	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 232	Continued From page 22 started the beginning of August. On 10/17/2024 at 2:33 PM, Surveyors emailed Licensee B requesting staff records for Residential Director A and Service Provider D to include a screening for communicable disease and TB test results. On 10/18/2024 at 11:08 AM, Surveyors received a follow up email from Licensee B stating the facility staff for the home include his/herself and Residential Director A, both hired 01/30/2024. Licensee B identified Service Provider D as a volunteer who was employed from 08/30/2024 to 09/06/2024. Licensee B did not provide Residential Director A or Service Provider D's screening for communicable disease and test results TB. On 10/21/2024 at 3:34 PM, Surveyor received an email from Licensee B stating, "...A communicable disease was not requested...I was advised it is good for 4 years and [s/he] has not traveled out of the country." S/he included an attachment in the email which reflected a communicable disease screen, dated 03/30/2022 and TB test results, dated 04/01/2022 for Residential Director A. On 10/22/2024 at 1:25 PM, Surveyors sent a follow up email to Licensee B explaining DHS 88.04(1)(g)1 and the results s/he emailed on 10/21/2024 for Residential Director A were not sufficient as it was completed in 2022. On 10/23/2024 at 11:28 AM, Surveyors received an email from Licensee B stating Residential Director A is scheduled for a TB test on 10/28/2024. S/he also reported Service Provider D is not currently employed at the home.	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain a safe, clean, and homelike environment. Findings include: The provider is licensed to care for up to 3 residents who may be developmentally disabled. On 09/16/2024 and 10/15/2024, the Department received a complaint alleging abuse, medication and environmental concerns in the home. On 10/17/2024 during a tour accompanied by Residential Director A at 11:04 AM, Surveyors observed the following: Kitchen/dining room: *One (1) of 6 chairs was missing an arm on the left side and the top of the table had a layer of dust. *The refrigerator and freezer had dried food splatter and residue on the shelves and on the bottom. Stairway leading up to the second level:	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 276	Continued From page 24 *The stairs were carpeted and had various dark spots/stains. Second level main bathroom: *The bathroom tub was full of water. Unoccupied resident room (upstairs and near the front of the house): *There was pink carpeting covering the entire floor. The carpeting had dark spots/stains throughout the room. At approximately 11:15 AM, Surveyors interviewed Residential Director A. Residential Director A was unable to explain why the bathtub was filled water. Residential Director A stated Licensee B is going to be buying a carpet cleaner and we will be cleaning the carpets. On 10/17/2024 at 4:46 PM, Surveyors received an email from Licensee B who stated, "The carpet in the "pink room" is very old. We are purchasing rugs placed that will not be a fall hazard." The provider did not ensure the home was clean and well-maintained.	M 276		
M 314	88.05(3)(i) BATHROOM LOCK The door of each bathroom shall have a lock which can be opened from the outside in an emergency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 bathroom doors had a lock	M 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 314	Continued From page 25 which was capable of being opened from the outside in an emergency. Findings include: On 10/17/2024 at approximately 11:04 AM during a tour of the home accompanied by Residential Director A, Surveyors observed a main bathroom on the second level of the home. (Surveyor note: Two (2) out of 3 resident bedrooms have access to a bathroom inside their rooms; however, the other resident room does not have access to a bathroom and utilizes the main bathroom.) There was a circular crystal-like knob on the inside and outside of the bathroom door, but the door did not have locking capabilities. Residential Director A acknowledged the bathroom door did not have a lock. While on tour, Residential Director A stated, "We are going to be changing the bathroom door lock, we just didn't get to it yet." *Surveyor note: Surveyor licensed the facility on 12/19/2023 and at that time the bathroom door lock was discussed and Licensee B indicated they would change it out to a door knob with locking capabilities. The provider did not ensure the bathroom door had the capability of being opened from the outside in an emergency putting 3 of 3 residents at risk for receiving help in an emergency.	M 314		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

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JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 332	Continued From page 26	M 332		

extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 2 of 2 fire extinguishers were inspected annually by an authorized dealer or the local fire department. The fire extinguishers had not been inspected since June 2023 and 1 of 3 observed was not mounted.

Findings Include:

The provider is licensed to care for up to 3 residents who may be developmentally disabled.

On 09/16/2024 and 10/15/2024, the Department received a complaint alleging abuse, medication and environmental concerns in the home.

On 10/17/2024 at approximately 11:04 AM during a tour of the home accompanied by Residential Director A, Surveyors observed 3 fire

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 332	Continued From page 27 extinguishers; 1 on the second level of the home, 1 near the dining room and another in the kitchen sitting on the floor near the back entrance. Surveyor observed the tags on the fire extinguishers and noted they were last inspected in June 2023. Residential Director A acknowledged Surveyors findings and stated s/he would let Licensee B know and have them inspected right away. On 10/17/2024 at 4:46 PM, Surveyors received an email from Licensee B stating, "The fire extinguishers are dated based on the day it was inspected and is good for one year." The provider did not ensure 3 of 3 fire extinguishers observed were inspected annually by an authorized dealer or the local fire department for the year 2024. In addition, the provider did not ensure 1 of 3 fire extinguishers was mounted.	M 332		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the 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.	M 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 380	Continued From page 28 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 (Resident 1 and 2) residents reviewed were screened for clinically apparent communicable disease, including tuberculosis (TB), within 90 days before or 7 days after admission. The provider did not have record of a TB test for Resident 1 or Resident 2. Findings include: On 10/17/2024 at approximately 10:15 AM, Surveyors requested Resident 1 and Resident 2's records from Residential Director A. Residential Director A stated Resident 1 is a newer admission and has been at the home for about a week. Residential Director A stated they did not have much documentation for Resident 1 as s/he was an emergency placement. Residential Director A confirmed s/he had Resident 2's record and stated s/he admitted on 05/25/2024 until his/her discharge date on 09/10/2024. Surveyors reviewed Resident 2's record and noted it did not include a screening for communicable disease or test results for TB. Residential Director A did not have Resident 1's record. On 10/17/2024 at 2:33 PM, Surveyors emailed Licensee B requesting resident records for Resident 1 and Resident 2 to include a screening for communicable disease and TB test results. On 10/18/2024 at 11:08 AM, Surveyors received a follow up email from Licensee B; however, s/he did not provide Resident 1 and Resident 2's screening for communicable disease or test results for TB. On 10/21/2024 at 1:25 PM, Surveyors sent	M 380		

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	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 380	Continued From page 29 another email to Licensee B requesting Resident 1 and Resident 2's records to include a screening for communicable disease and TB test results. On 10/21/2024 at 3:24 PM, Surveyors received an email from Licensee B stating, "...I have provided all of [Resident 1's] information received thus far. [S/he] was an emergency placement due to 30 day notice. We are transitioning [him/her] to a primary care doctor and [him/her] appointment has been scheduled." On 10/22/2024 at 9:31 AM, Surveyors received a follow up email from Licensee B confirming Resident 1 "had been in our care for 9 days at the time of your visit." Licensee B did not provide any additional documentation showing Resident 1 and Resident 2 were screened for clinically apparent communicable disease, including TB. The provider did not ensure Resident 1 and Resident 2 were tested for clinically apparent communicable disease, including tuberculosis, within 90 days prior to or 7 days after admission.	M 380		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on interview and record review, the licensee did not develop an individual service plan (ISP) to address the needs and abilities in	M 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 410	Continued From page 30	M 410		

the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation for 1 of 2 (Resident 2) residents reviewed.

Resident 2 was admitted to the facility on 05/25/2024. Resident 2 discharged from the facility on 09/11/2024. Resident 2's closed record did not contain an ISP.

Findings Include:

On 09/16/2024 and 10/15/2024, the department received complaints alleging abuse, medication mismanagement and environmental concerns.

On 10/17/2024 at 10:00 AM, Surveyors conducted an onsite visit to the home. The home is licensed to provide care up to 3 residents with developmental disabilities. Upon entering the home, Surveyors requested to review Resident 2's record. Resident 2 was admitted to the facility on 05/25/2024 with diagnoses to include William's Syndrome (genetic disorder) and hypochondria. Resident 2 discharged from the home on 09/11/2024. Resident 2's record did not contain an ISP to address the needs and abilities in the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation.

On 10/17/2024 at 10:30 AM, Surveyor interviewed Residential Director A. Residential Director A stated the only information s/he had was provided to Surveyor. Residential Director A suggested Surveyor contact Licensee A regarding any additional records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 410	Continued From page 31 On 10/17/2024 at 1:33 PM, Surveyor emailed Licensee B requesting Resident 2's ISP. On 10/18/2024 at 11:08 AM, Licensee B sent an email regarding Resident 2's ISP stating, "[Residential Director A] attended a care plan meeting with [Resident 2'] IRIS [Include, Respect, I-Self Direct] Consultant [name removed] in June 2024 and upon request the final plan was never received. There was no additional information provided from IRIS/TMG [The Management Group] during the intake process as the new consultant was being assigned." No further documentation was provided to Surveyor regarding Resident 2's ISP. Cross Reference M0218 88.04(2)(a) Awake Staff For Continuous Care	M 410		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all prescription medications were	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 458	Continued From page 32	M 458		

securely stored. Resident 1's prescription medications were unsecured in a storage box and in the living room.

Findings include:

The provider is licensed to care for up to 3 residents who may be developmentally disabled.

On 09/16/2024 and 10/15/2024, the Department received a complaint alleging abuse, medication and environmental concerns in the home.

On 10/17/2024 at approximately 11:20 AM, while conducting a tour of the home accompanied by Residential Director A, Surveyors observed an open kitchen cabinet with an opened storage box sitting on the shelf. Residential Director A removed the opened storage box and placed it on the kitchen counter. Surveyor observed there were medications belonging to Resident 1 inside of the storage box and a lock on the outside of the box. Surveyor observed the lock on the storage box did not latch or lock when the cover was closed. Surveyor did not observe a locking mechanism on the cabinet utilized to store resident medications. In addition, Surveyors observed a prescription tube of Metronidazole Topical Cream was left unsecured on a shelf in the living room. Resident 1 confirmed the cream was his/hers.

At approximately 11:30 AM, Surveyor interviewed Residential Director A. Residential Director A confirmed resident medications are kept in the unopened storage box within the open cabinet. Residential Director A confirmed the cabinet did not lock. Additionally, Residential Director A stated Licensee B has the keys to the storage box, so Residential Director A had to break the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 458	Continued From page 33 lock to get the box open so Residential Director A could store Resident 1's medications in the box. On 10/22/2024 at 9:31 AM, Surveyors received an email from Licensee B stating, "The medication was stored in a box behind a locked door that was broken down by [Resident 2]; the door was re-hinged, however, came off when a new resident was being moved in. A new lock box has been purchased and the door is being re-hung again."	M 458		
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 interview and record review, the licensee or service provider did not obtain and keep a written order from the physician who prescribed the medication prior to dispensing or administering the prescription medication to 1 of 1 (Resident 2) residents reviewed. Resident 2 admitted to the facility on 05/25/2024. Resident 2's record did not include written	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 464	Continued From page 34	M 464		

physician orders for any medications Resident 2 had taken. Resident 2 discharged from the facility on 09/11/2024.

Findings Include:

On 09/16/2024 and 10/15/2024, the department received complaints regarding abuse, medications and environment.

On 10/17/2024, Surveyors conducted an onsite visit to the home. Upon entering, Surveyor requested Resident 2's resident record including admission paperwork, individual service plan (ISP) and medication administration record (MAR). Residential Director A provided Surveyor with Resident 2's record. The following was noted.

Resident 2 admitted to the home on 05/25/2024 with diagnoses to include William's Syndrome and hypochondria. Resident 2 discharged from the home on 09/11/2024. Resident 2's May/June 2024 MAR indicated Resident 2 was receiving the following medications:
*Ketoconazole 2%(percent) shampoo to be used 2 times per week
*Buspirone 5mg (milligrams) take 1 tablet 2 times a day for 14 days, then stop
*Fish Oil 1,000mg take 1 capsule by mouth daily
*Glucos-Chondr 500-400mg take 1 tablet by mouth daily
*Omeprazole DR 40mg take 1 capsule by mouth daily
*Quercetin 500mg take 1 capsule by mouth daily
*Melatonin 5mg take 1 tablet by mouth at bedtime
*Polyethylene Glycol dissolve 17grams in 8 ounces of liquid and take by mouth daily
*Lorazepam 0.5mg take 1 tablet by mouth 2 times daily as needed for anxiety/agitation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 464	Continued From page 35	M 464		

*Naproxen 500mg take 1 tablet by mouth 2 times daily as needed

Resident 2 was seen by a physician on 07/25/2024 with instructions to take the following medications:
*Acetaminophen 325mg take 650mg every 4 hours as needed for pain
*Baclofen 10mg take 1 tablet three times a day
*Bupropion 150mg take 1 tablet once a day
*Buspirone 15mg take 1 tablet once a day
*Fluoxetine 10mg take 1 tablet once a day
*Multi vitamin take 1 tablet daily
*Naproxen 500mg take 1 tablet 2 times a day as needed for pain
*Naproxen Sodium 220mg take 1 tablet 2 times daily
*Omeprazole 40mg take 1 capsule a day
*Vitamin C 500mg take 1 tablet a day

On 10/17/2024 at 1:33 PM, Surveyor requested additional documentation via email from Licensee B including Resident 2's physician orders during Resident 2's stay at the home.

On 10/21/2024 at 3:24 PM, Surveyor received an email from Licensee B which stated, "I sent a number of documents from J4M's email server regarding [Resident 2] At your visit, you took pictures of [his/her] medication order and last physician visit. [Guardian C] has the physician orders."

On 10/23/2024 at 11:12 AM, Licensee B stated the following, "...[Guardian C] has [his/her] physician orders outside of what is in [his/her] file. J4M's assessments were completed."

On 10/30/2024 at approximately 1:00 PM, Surveyor interviewed Licensee B and Residential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 464	Continued From page 36 Director A regarding physician orders. Licensee B stated, "We will take ownership of the fact we did not have the physician orders, but we relied on what was sent from the pharmacy and the orders they received. That was our checks and balances." Cross Reference: M0466 88.07(3)(e)1 - Medication Record Keeping M0468 88.07(3)(e)2 - Medication - Record of Side Effects	M 464		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not keep a record of all prescription medications controlled, dispensed or administered by the licensee or service provider for 1 of 2 (Resident 2) residents reviewed. Resident 2 did not have a record of prescription medications controlled, dispensed or administered between 05/25/2024-05/31/2024 and 07/15/2024-07/30/2024. Additionally, Resident 2's August 2024 Medication	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 466	Continued From page 37 Administration Record (MAR) contained 2 rows that stated "AM" with staff initials in each date box (08/01/2024-08/31/2024) but did not list the medication that was given. Resident 2's September 2024 MAR did not contain 3 medications that Resident 2 was prescribed. On 08/29/2024, 08/30/2024 and 08/31/2024, Resident 2 did not receive Fluoxetine 10mg and Omeprazole 40mg, however, the MAR indicated Omeprazole was given on those dates. The MAR does not have Fluoxetine listed as a medication to be given. On 09/10/2024 and 09/11/2024, Resident 2 did not receive Buspirone at 8:00AM, however, the MAR indicated Buspirone was given on 09/10/2024 and there is no record for 09/11/2024. Findings Include: On 09/16/2024 and 10/15/2024, the department received complaints regarding medication administration. On 10/17/2024, Surveyors conducted an onsite visit at the home. Upon entering, Surveyor requested Resident 2's record. Resident 2 was admitted to the facility on 05/25/2024. Resident 2 was discharged from the facility on 09/11/2024. Surveyor reviewed Resident 2's May, June, July 2024 MAR. Resident 2's record did not contain physician orders to confirm Resident 2's medication regime at the time Resident 2 resided at the home. Surveyor noted the following dates when medications were not documented as received per no staff initials on Resident 2's MARs: 05/25/2024-05/31/2024	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 466	Continued From page 38	M 466		

Ketoconazole 2%(percent) shampoo to be used 2 times per week
Buspirone 5mg(milligrams) take 1 tablet 2 times daily for 14 days, then stop

07/15/2024-07/30/2024
Buspirone 5mg take 1 tablet 2 times daily
Fish Oil 1,000mg take 1 tablet once a day
Glucos-Chondr 500 or 400mg take 1 tablet once a day
Omeprazole 40mg take 1 tablet once a day
Melatonin 5mg take 1 tablet once a day
Polyethylene Glycol 17gm(grams) in liquid to be taken once a day
Fluoxetine 10mg take 1 tablet once a day

At approximately 10:30 AM, Surveyor interviewed Residential Director A. Residential Director A stated s/he sent the August and September 2024 MAR with Guardian C when s/he picked up Resident 2 on 09/11/2024. Residential Director A indicated s/he did not keep a copy of the August and/or September 2024 MAR.

On 10/17/2024 at 1:33 PM, Surveyor requested Resident 2's August and September 2024 MAR from Licensee B via email.

On 10/18/2024 at 11:59 AM, Surveyor received Resident 2's August and September 2024 MAR from Licensee B. Surveyor noted the following:
*The August 2024 MAR contained 2 rows that stated "AM" with staff initials in each date box (08/01/2024-08/31/2024), however, it did not list what medication were given on that date.
*The September 2024 MAR did not contain documentation to show Lorazepam 0.5mg to be taken 2 times daily, Buspirone 15mg to be taken 2 times daily and Fluoxetine 10mg to be taken once a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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 466	Continued From page 39 On 10/21/2024 at 3:20 PM, Surveyor interviewed Guardian C. Guardian C verified s/he is the guardian for Resident 2. Guardian C stated that upon discharge, Residential Director A gave Guardian C all of Resident 2's medications. Guardian C stated there were pills missing and there were pills Resident 2 didn't get. Guardian C stated in early August, the physician increased Buspirone and Resident 2 didn't get all of those along with several days in September Resident 2 didn't get the additional dose. Guardian C stated Resident 2 also did not get Omeprazole 3 days in August. Guardian C stated s/he will send a picture of the medications Residential Director A gave him/her upon discharge that Resident 2 did not receive. Guardian C stated s/he did not receive any MAR from Residential Director A upon discharge, no paper copy was received. On 10/24/2024 at 10:06 AM, Surveyor received an email from Guardian C with a picture of Resident 2's unopened medications. [Picture 1] Surveyor reviewed the picture and noted the following: *On 08/29/2024, 08/30/2024 and 08/31/2024, Resident 2 did not receive Fluoxetine 10mg and Omeprazole 40mg, however, the MAR indicated Omeprazole was given on those dates. The MAR does not have Fluoxetine listed as a medication to be given. *On 09/10/2024 and 09/11/2024, Resident 2 did not receive Buspirone at 8:00AM, however, the MAR indicated Buspirone was given on 09/10/2024 and there is no record it was given on 09/11/2024. On 10/24/2024 at 2:25 PM, Surveyor interviewed Pharmacy Technician E. Pharmacy Technician E verified s/he worked for the pharmacy which	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 466	Continued From page 40	M 466		

supplied Resident 2's medications to the home. Pharmacy Technician E stated Resident 2 would have had June medications with him/her when Resident 2 admitted to the home on 05/25/2024. Pharmacy Technician E stated at that time Resident 2 had orders for Buspirone 5mg twice a day to be stopped after 14 days, however, the physician renewed the prescription on 06/07/2024 to continue. On 08/08/2024, the physician increased the dose to 10mg twice a day and then on 09/06/2024 to 15mg twice a day. Resident 2's Lorazepam 0.5mg was a PRN (as needed) but on 08/07/2024 it was changed to 0.5mg twice a day (scheduled). Lastly, Resident 2's Fluoxetine 10mg was ordered on 07/11/2024, but Resident 2 or Guardian C did not want to take it so the pharmacy didn't send it initially but on 08/01/2024 Resident 2 or Guardian C agreed to take it and the medication was sent to the home.

On 10/30/2024 at approximately 1:00 PM, Surveyor interviewed Licensee B and Residential Director A regarding medication administration. Licensee B stated s/he received no documentation from Resident 2's previous facility. Licensee B stated Guardian C had all of Resident 2's medications in a bag and told Licensee B what to give Resident 2 so s/he wasn't "loopy." Licensee B was unsure if Guardian C provided a MAR. Licensee B stated then they actually talked to the pharmacy and they mailed the medications to us monthly. Licensee B stated Guardian C was transitioning to the area and was setting up Resident 2's physician visits as s/he wanted to be in charge of setting those up. Per Licensee B, Resident 2's move happened really fast. Guardian C had provided a 30 day notice at Resident 2's last placement but then moved up the moving date. Licensee B stated Resident 2 was having escalated behaviors (kicking, volatile,

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	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 466	Continued From page 41	M 466		

invading spaces) and Guardian C would ask psychiatrist to have medications added. Licensee B stated we tried to de-escalate those behaviors, but we were not involved with determining what medications Resident 2 should be prescribed. "[Guardian C] was in charge of that." Surveyor asked about the prescription for Fluoxetine. Licensee B stated, "We didn't give it long...After the behaviors increased, I believe the Prozac [fluoxetine] was prn [as needed] I can't remember off the top of my head. I will have to look back. I have texts from [Guardian C] about this all. [Guardian C] took the lead and said what was working. Some of those other pieces I'll have to look back on." Residential Director A stated, "The doctor even agreed not to give it to [Resident 2]." Licensee B stated, "We can give you the conversations. We took notes and I have communications via text and email. I can give you documented times we had dialogue. At the end of the day, the person who gave direction to doctor was [Guardian C]. I know Lorazepam was a PRN. Had to document when it was given. I was not aware it went to a scheduled medication. [Residential Director A] was aware, but when I was in charge of disseminating, it was not because of the behaviors and [him/her] walking backwards. Residential Director A stated, "Everything [Resident 2] was scheduled to get, [s/he] was given [his/her] meds. Surveyor discussed the discrepancies with the August/September MARS. Residential Director A stated, "Everything was filled out on there...Changes occurred just before [s/he] left. Surveyor questioned the MAR being initialed but no medication listed by the initials. Residential Director A stated, "Yeah, I don't know. This is from a while ago, so I would need to look at it. [S/he] got everything that came monthly." Licensee A stated, "What was mailed out from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 466	Continued From page 42 [pharmacy], that is what we utilized to ensure [s/he] was given what was authorized. If there was a medication missing, we would reach out to the [pharmacy]. [Pharmacy] was our point of contact to ensure we were giving [him/her] the medications we were authorized to give." Licensee B stated they will documentation from all of this. Residential Director A stated s/he gave Guardian C all Resident 2's medications in a plastic bag, "Everything that was in [his/her] box and everything from that box was sent with [him/her]. There were no missing medications." On 10/31/2024 at 2:27 PM, Surveyor received an email from Licensee B with pictures of text messages between Licensee B, Residential Director A and Guardian C. Surveyor noted, none of the text messages included physician orders. Additionally, none of the text messages referenced missing medications or changes to medications during the timeframe mentioned above. Cross Reference M0464 88.07(3)(d) Medication - Written Order	M 466		
M 468	88.07(3)(e)2 MEDICATION- RECORD OF SIDE EFFECTS The record shall also contain information describing potential side effects and adverse reactions caused by each prescription medication. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure 1 of 2 (Resident 2) resident records reviewed contained information describing potential side effects and adverse	M 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 468	Continued From page 43	M 468		

reactions caused by each prescription medication.

Resident 2 was admitted on 05/25/2024. Resident 2 was discharged on 09/11/2024. Resident 2's record did not contain information describing potential side effects and adverse reactions caused by each prescription medication.

Findings Include:

On 09/16/2024 and 10/15/2024, the department received complaints regarding medications.

On 10/17/2024, Surveyors conducted an onsite visit to the home. Upon entering the home, Surveyor requested Resident 2's record. Resident 2 was admitted to the facility on 05/25/2024 with diagnoses to include William's Syndrome and Hypochondria. Resident 2 discharged on 09/11/2024. Resident 2's record did include Medication Administration Records (MAR) from May, June, July, August and September 2024 indicating Resident 2 received multiple medications while residing at the facility. Surveyor did not observe Resident 2's record to contain information describing potential side effects and adverse reactions for each of the prescription medications Resident 2 was receiving.

On 10/17/2024 at approximately 10:30 AM, Surveyor interviewed Residential Director A. Residential Director A stated s/he did not have any additional documentation for Resident 2. Residential Director A instructed Surveyor to contact Licensee B for additional documentation.

On 10/17/2024 at 2:33 PM, Surveyor sent Licensee B an email requesting additional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 468	Continued From page 44 documentation regarding Resident 2. On 10/18/2024 at 11:08 AM, Surveyor received an email from Licensee B with no additional documentation related to Resident 2's record regarding information related to medication side effects or potential adverse health reactions. Cross Reference: M0464 88.07(3)(d) Medication Written Order	M 468		
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 1 of 1 residents had privacy in their own home. There were 2 cameras in the home; one in the entryway and one on the second level used by all residents. Findings Include:	M 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 550	Continued From page 45 The provider is licensed to care for up to 3 residents who may be developmentally disabled. On 09/16/2024 and 10/15/2024, the Department received complaints alleging abuse, medication and environmental concerns in the home. On 10/17/2024 at approximately 11:04 AM during a tour of the home accompanied by Residential Director A, Surveyors observed a camera in the entryway of the home. The camera was sitting on a table and aimed toward the entryway and living room area used by residents. A second camera was located on the second level in the hallway near an unoccupied resident room. The camera was sitting on top of a lamp post in the corner of the hallway and would rotate when there was movement. The camera was pointed towards three resident bedroom doors, the stairway and the main bathroom. Residents would be captured walking down the hall, going up and down the stairs, entering and exiting their rooms and a bathroom. Surveyor note: Two (2) of 3 resident rooms had their own bathroom inside their bedrooms; however, the resident bedroom without the bathroom would need to utilize the main bathroom across the hallway. On 10/17/2024 at approximately 11:10 AM, Surveyors inquired about the use of the cameras with Residential Director A. Surveyors explained cameras in these areas are an invasion of privacy. S/he stated s/he did not know that and immediately removed the camera on the second level and placed it in his/her pocket. Surveyors also observed as Residential Director A unplugged and removed the camera from the entryway. Residential Director A stated s/he put the camera up on the second level about a week ago because Resident 1 was coming out of	M 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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M 550	Continued From page 46 his/her room. S/he did not know when the one in the entryway was put up. On 10/17/2024 at 4:46 PM, Surveyors received an email from Licensee B stating, "Cameras have been removed..." On 10/21/2024 at 3:30 PM, Surveyors interviewed Guardian C. Guardian C stated "Cameras are everywhere so they [staff] could see on their phones." On 10/22/2024 at 9:31 AM, Surveyors received an additional email from Licensee B stating, "There was a camera at the front door...and hallway upstairs. Both are common areas. This was in place for resident protections only." On 10/23/2024 at 11:28 AM, Surveyors received an email from Licensee B who stated, "On the spot corrections regarding the cameras in common were done during your visit on Thursday, October 17, 2024." On 10/24/2024, Surveyor reviewed the provider's program statement. The program statement does not indicate the use of cameras/video monitoring in the home. The provider did not ensure 1 of 1 residents had privacy in their own home.	M 550		
Z 005	50.065(2)(b)intro ENTITY BACKGROUND CHECK REQUIREMENTS 1. A criminal history search from the records maintained by the department of justice.	Z 005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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Z 005	Continued From page 47 2. Every entity shall obtain all of the following with respect to a caregiver of the entity: Information that is contained in the registry under s. 146.40(4g) regarding any findings against the person. 3. Information maintained by the department of safety and professional services regarding the status of the person's credentials, if applicable. 4. Information maintained by the department regarding any final determination under s. 48.981(3)(c)5m. or, if a contested case hearing is held on such a determination, any final decision under s. 48.981(3)(c)5p. that the person has abused or neglected a child. 5. Information maintained by the department under this section regarding any denial to the person of a license, certification, certificate of approval or registration or of a continuation of a license, certification, certificate of approval or registration to operate an entity for a reason specified in sub. (4m)(a)1. to 5. and regarding any denial to the person of employment at, a contract with or permission to reside at an entity for a reason specified in sub. (4m)(b)1. to 5. If the information obtained under this subdivision indicates that the person has been denied a license, certification, certificate of approval or registration, continuation of a license, certification, certificate of approval or registration, a contract, employment or permission to reside as described in this subdivision, the entity need not obtain the information specified in subds. 1. to 4.	Z 005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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
Z 005	Continued From page 48	Z 005		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at the time of hire a background check was conducted for 2 of 2 (Residential Director A and Service Provider D) staff reviewed. The complete background check is to include the background information disclosure form (BID), the criminal history search from the department of justice (DOJ), and the information maintained by the department of safety and professional services regarding a person's credentials (IBIS).

Findings include:

On 09/16/2024 and 10/15/2024, the Department received a complaint alleging abuse, medication and environmental concerns in the home.

On 10/17/2024 at 10:05 AM, Surveyors met with Residential Director A upon arrival to the home. Residential Director A verified s/he and Service Provider D are the only employees in the home. S/he reported Service Provider D helps out when needed otherwise Residential Director A is in the home the majority of the time. Residential Director A stated Licensee B is on call and fills in as needed as well. Residential Director A confirmed s/he does not have access to staff records and Surveyors would need to request records from Licensee B. Residential Director A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

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Z 005	Continued From page 49	Z 005		

stated s/he started working in the home towards the end of May and Service Provider D started the beginning of August.

On 10/17/2024 at 1:33 PM, Surveyors emailed Licensee B requesting staff records for Residential Director A and Service Provider D including their complete background checks to include the BID, IBIS and DOJ and their dates of hire.

On 10/18/2024 at 11:08 AM, Surveyors received a follow up email from Licensee B stating the facility staff for the home include his/herself and Residential Director A, both hired 01/30/2024. Licensee B identified Service Provider D as a volunteer who was employed from 08/30/2024 to 09/06/2024. S/he included an attachment which was identified as "[Residential Director A] Background Check" and there were 3 rows in the document which read: (Row 1) "Date background checklist completed: (blank)"; (Row 2) "[Residential Director A]: DOH (Date of Hire) January 30, 2024"; and (Row 3) "BID Completed January 2024 DHS (Department of Health Services) Results Passed." Licensee B did not provide the BID, IBIS or DOJ reports.

On 10/21/2024 at 1:25 PM, Surveyors sent another email to Licensee B requesting Residential Director A and Service Provider D's staff records to include the completed BID and the IBIS and DOJ reports.

On 10/21/2024 at 3:24 PM, Surveyors received a follow up from Licensee B stating, "I will [sic] be able to submit any additional notes due to confidentiality...[Residential Director A], applied for 2 positions (including J4M (Just 4 Me)) in January 2024 and a DQA [Division of Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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
Z 005	Continued From page 50 Assurance] background was submitted by Manitowoc Health and Rehabilitation Center and approved which I used as verification. [S/he] provided supplemental information related to a previous arrest that was included." Licensee B also stated Service Provider D has not officially started as staff. No additional documentation was provided. On 10/23/2024 at 8:23 AM, Surveyors received an email from Licensee B with attachments to include Residential Director A's BID, dated 10/21/2024 and IBIS, dated 10/22/2024. Licensee B did not provide the DOJ report. On 10/23/2024 at 1:21 PM, Surveyors sent a follow up to Licensee B requesting the DOJ report for Residential Director A. On 10/23/2024 at 1:45 PM, Licensee B responded via email stating, "I did not upload the form - it was filled out for J4M's records, I input the caregiver information and provided the documentation of submission and receipt. I do not have any additional documents to provide." The provider did not complete a background check when Residential Director A and Service Provider D were hired as an employee or volunteer. Cross Reference: M0230 88.04(2)(f) Condition which represents Risk or Harm Z0055 13.05(3)(a) Entity Allegation Reporting Requirement	Z 005		
Z 055	DHS 13.05 (3) (a) ENTITY ALLEGATION REPORTING REQUIREMENTS	Z 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST 4 ME ADULT FAMILY HOME	635 N 8TH STREET MANITOWOC, WI 54220

(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
Z 055	Continued From page 51 Entity's duty to report to the department. Except as provided under pars. (b) and (c), an entity shall report to the department any allegation of an act, omission or course of conduct described in this chapter as client abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity. The entity shall submit its report on a form provided by the department within 7 calendar days from the date the entity knew or should have known about the misconduct. The report shall contain whatever information the department requires. This Rule is not met as evidenced by: Based on interview and record review, the entity did not submit a report to the department within 7 calendar days from the date they knew about an allegation of misconduct. On 09/11/2024, Resident 2's legal representative (Guardian C) informed Licensee B and Residential Director A, Resident 2 had made statements to Guardian C that s/he had been physically abused by Residential Director A and Residential Director A's family members. Findings Include: On 09/16/2024 and 10/15/2024, the department received complaints regarding physical abuse.	Z 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

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(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
Z 055	Continued From page 52 On 10/17/2024, Surveyors conducted an onsite visit to the home. Resident 2 admitted to the facility on 05/25/2024 with the following diagnoses, Williams' Syndrome (genetic disorder) and hypochondria. Resident 2's record reflected Resident 2 was under court appointed guardianship, with Guardian C named as guardian. Resident 2 discharged from the facility on 09/11/2024. On 10/17/2024 at 10:15 AM, Surveyor interviewed Residential Director A. Residential Director A indicated s/he has a 17 year old, 15 year old, 14 year old and 8 year old who do come to the home and interact with residents such as watch T.V., play games, make food or help with taking medications to residents but never distributing them to the residents. Residential Director A indicated the children do not live in the home, as Residential Director A has a home just about a block away from the adult family home. Residential Director A stated Guardian C and/or Resident 2 never complained of anything. Surveyor requested to review Resident 2's resident record. On 10/17/2024 at 10:35 AM, Surveyor reviewed Resident 2's daily progress notes. A note written by Residential Director A dated 09/11/2024 stated, "[Guardian C] came to pick up [Resident 2] and [s/he] says [s/he] will not be back due to lack of care and also acussed [sic] my family of harming [him/her]..." On 10/17/2024 at approximately 1:30 PM, Surveyor received the following note via email from Licensee B. "[Guardian C] never reported any concerns of abuse and/nor neglect..."	Z 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

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Z 055	Continued From page 53 Additionally, on 10/18/2024 at 11:08 AM, Licensee B stated the following via email, "Outside of outlandish statements (ex. a petite/2 foot 8-year-old "whooping [Resident 2]" with a belt) made by [Guardian C] on the day [s/he] abruptly terminated [his/her] placement, I have not received notifications of any specific complaints. It has all felt like a "fishing expedition" which unfortunately, is not surprising based on attempts to weaponize the police, utilize intimidation strategies etc." On 10/21/2024 at 3:20 PM, Surveyor interviewed Guardian C. Guardian C stated on 09/10/2024 Resident 2 informed of him/her that Residential Director A whipped Resident 2 with a belt once, Residential Director A's 17 year old son also whipped Resident 2 once with a belt and Residential Director A's 14 year old did so more than once. Resident 2 indicated to Guardian C it had been going on for several months but was afraid to tell Guardian C because it would get worse. Guardian C stated s/he asked Resident 2 multiple times if s/he was telling the truth and Resident 2 confirmed s/he was telling the truth. Guardian C stated s/he contacted Adult Protective Services to inform them of the concerns. Guardian C stated s/he confronted Residential Director A on 09/11/2024 about the accusations. Guardian C stated Residential Director A denied the accusations. Guardian C stated s/he also let Licensee B know about the accusations and Licensee B directed him/her to bring them to Residential Director A. Guardian C stated, "That's stupid to go back to [Residential Director A] because [s/he] is the only person working there and the accusations are against [him/her]." On 10/21/2024, Surveyor reviewed the	Z 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019756	A. BUILDING: _____ B. WING _____	C 12/09/2024

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Z 055	Continued From page 54 department's facility folder. Surveyor did not see a Misconduct Incident Report (MIR) regarding the abuse allegations. In summary, on 09/11/2024 Licensee B and Residential Director A were informed of an allegation of physical abuse. Licensee B and Residential Director A did not report this allegation to the licensing agency. Cross Reference: M0230 88.04(2)(f) Condition which represents Risk or Harm Z0005 50.065(2)(b) Entity Background Check Requirements	Z 055		