STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019862	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOGGY HOME	2104 FOGGY MOUNTAIN PASS WAUNAKEE, WI 53597

(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 08/19/2026, Surveyor conducted a standard survey at Foggy Home, an AFH in Waunakee. One deficiency was identified. Census: 3	M 000		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 2 individual service plans (ISP) reviewed included a full description of services the licensee would provide to meet assessed needs. Resident 1's ISP did not include his/her use of a vest, seatbelt and wheelchair chair. Findings include: On 08/19/2026 at approximately 7:50 a.m., Surveyor observed Resident 1 in the provider's living room. Resident 1 was sitting in a wheelchair, equipped with a vest, seatbelt and wheelchair tray in place. On 08/19/2026 at 8:15 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 10/25/2025 with	M 412		

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
	0019862	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOGGY HOME	2104 FOGGY MOUNTAIN PASS WAUNAKEE, WI 53597

(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 412	Continued From page 1 diagnoses including cerebral palsy. Resident 1's individual service plan (ISP), dated 02/28/2026 and behavioral support plan (BSP), dated 04/21/2026, did not address the use of a vest, seatbelt or wheelchair tray. On 08/19/2026 at approximately 9:50 a.m., Surveyor interviewed Licensee A and Manager B. Surveyor asked why Resident 1 used a vest, seatbelt and wheelchair tray. Licensee A replied, "I believe [s/he] falls forward otherwise" and stated the devices had been used since admission. Manager A added that Resident 1's tray table was used while working at day program, which resident had left to attend. Surveyor discussed concern that neither the vest, seatbelt, nor wheelchair tray were identified in Resident 1's ISP. Licensee A stated s/he would update the ISP.	M 412		