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	0017420	A. BUILDING: _____ B. WING _____	10/14/2025

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M 000	INITIAL COMMENTS On 10/14/2025, Surveyor conducted a standard survey at Just Grace Assisted Living. As a result, 10 deficiencies were identified. Census: 4	M 000		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all service providers involved in the operation of the adult family home complied with the universal precautions contained in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. Licensee A and Licensee B did not complete annual training regarding universal precautions in 2023 and 2024. Findings include: U.S. OSHA Standard 29 CFR 1910.1030 states, in part: "The employer shall train each employee with occupational exposure in accordance with the requirements of this section. Such training	M 235		

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

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M 235	Continued From page 1 must be provided at no cost to the employee and during working hours. The employer shall institute a training program and ensure employee participation in the program. Training shall be provided as follows: At the time of initial assignment to tasks where occupational exposure may take place; At least annually thereafter." The provider was licensed to provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, physically disabled, developmentally disabled, advanced aged, terminally ill, emotionally disturbed/mental illness, and correctional clients. On 10/14/2025, Surveyor reviewed Licensee A's and Licensee B's training records. Licensee A and Licensee B were hired 05/2020. Licensee A's and Licensee B's record did not contain annual training for universal precautions related to the control of blood-borne pathogens in 2023 and 2024. On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Licensee B stated s/he knew that they had not completed all the required continuing education for 2023 and 2024, but s/he would ensure they completed training in 2025. Licensee B reported they had the possibility of being exposed to blood-borne pathogens when assisting residents as they covered shifts.	M 235		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service	M 246		

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M 246	Continued From page 2 provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 staff members (Licensee A and Licensee B) received at least 8 hours per calendar year of continuing education training related to the health, safety, welfare, rights, and treatment of residents every year, during the calendar year 2023 and 2024. Findings include: On 10/14/2025, Surveyor reviewed Licensee A's and Licensee B's training records. Licensee A and Licensee B were licensed 05/2020. Licensee A's and Licensee B's record did not contain any continuing education courses in 2023 and 2024. On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Licensee B stated s/he knew that they had not completed all the required continuing education for 2023 and 2024, but s/he would ensure they completed training in 2025.	M 246		

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M 262	Continued From page 3	M 262		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview the provider did not ensure that access within the home was provided for a resident who was unable to ambulate without the use of a walker. The home did not have 2 exits ramped to grade. Findings include: The provider was licensed to provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, physically disabled,	M 262		

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M 262	Continued From page 4 developmentally disabled, advanced aged, terminally ill, emotionally disturbed/mental illness, and correctional clients. On 10/14/2025, at approximately 10:50 AM, Surveyor arrived at the home, walked up 3 steps, and observed a walker sitting on the deck. Surveyor walked into the home and observed a walker next to Resident 2. On 10/14/2025, at approximately 11:30 AM, Surveyor observed Resident 1 ambulate to his/her room while utilizing his/her walker. On 10/14/2025, Surveyor reviewed Resident 2's record. Resident 2 moved into the home 09/2021. Resident 2's individual service plan, dated 09/21/2023, documented: Medical Equipment: Walker On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Surveyor asked for clarification as to when Resident 2 began to utilize his/her walker, as the home was not licensed for non-ambulatory residents and the home currently would not be licensed as a non-ambulatory home. Licensee B stated that when Resident 2 moved into the home, s/he did not utilize a walker, but s/he had become weaker over time. Surveyor shared information with Licensee B on the requirements for a home to be licensed as ambulatory with conditions. Licensee B stated s/he would review this information and determine if they could complete an amendment to ambulatory with conditions.	M 262		

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M 262	Continued From page 5 Wisconsin Department of Health Services defines 'Ambulatory with conditions' for an AFH (adult family home) as settings which serve residents who are able to walk only with difficulty, walk only with the help of crutches, a cane, or walker, or aren't able to easily negotiate stairs without help. These settings may not serve residents who use wheelchairs or who aren't able to walk at all. The setting must comply with Wis. Admin. Code. § DHS 88.05(2) "Residents shall be able to easily enter and exit the home, to easily get to their sleeping rooms, a bathroom, the kitchen and all common living areas in the home, and to easily move about in the home." The setting must comply with Wis. Admin. Code. § DHS 88.05(2)(a)1 Exits ramped to grade with a hard surfaced pathway with handrails. The program statement and admission agreement must include information on the potential for discharge if a resident has a change in ambulation status and the setting is unable to obtain a waiver or change the licensure status.	M 262		
M 276	88.05(3)(a) Homelike 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 ensure the adult family home's physical	M 276		

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M 276	Continued From page 6 environment was safe, well maintained, and appropriate to provide a homelike environment to residents. Findings include: On 10/14/2025, at approximately 11:00 AM, Surveyor toured the home and observed: Resident Bathroom: Wall vent was covered in a rust-colored substance Window blinds had a dust like substance buildup Windowpanes had a dust like substance buildup Toilet paper dispenser contained a cardboard roll with no toilet paper There were no hand towels available Bathroom tile floor had what appeared to be a dust buildup and grime buildup along the baseboards Surveyor observed Resident 1 and Resident 2 utilize the bathroom on several occasions during the survey. On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Licensee B stated s/he would discuss the concerns with staff.	M 276		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than	M 346		

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M 346	Continued From page 7 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 2 and Resident 3) reviewed were evaluated annually for evacuation time, using the department's form. Findings include: The provider was licensed to provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, physically disabled, developmentally disabled, advanced aged, terminally ill, emotionally disturbed/mental illness, and correctional clients. On 10/14/2025, Surveyor reviewed Resident 2's and Resident 3's record. Resident 2 moved into the home 09/2021. Resident 2's record contained an evacuation assessment form dated 09/15/2021. The evacuation assessment form should have been updated in 2022, 2023, 2024 and 2025. Resident 3 moved into the home 05/2022. Resident 3's record did not contain an evacuation assessment form. The evacuation assessment form should have been updated in 2022, 2023, 2024 and 2025. On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Surveyor explained that the evacuation assessments are to be completed annually. Licensee B stated s/he would review Resident 2's	M 346		

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M 346	Continued From page 8 record and update it accordingly. Licensee B stated s/he knows Resident 3 had been assessed when s/he moved in but was unable to locate that documentation, but s/he admitted it had not been updated as required. Licensee B stated s/he would update all resident records.	M 346		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 resident's (Resident 2 and Resident 3) Individual Service Plans (ISP) were reviewed at least every 6 months and signatures were obtained of the appropriate parties to indicate agreement with the resident's ISP. The provider did not ensure 1 of 1 resident's ISP	M 424		

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was updated to reflect his/her change of conditions. Resident 2's ISP did not reflect that s/he displayed verbal aggression and was not allowed to hold his/her cigarettes.

Findings include:

The provider was licensed to provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, physically disabled, developmentally disabled, advanced aged, terminally ill, emotionally disturbed/mental illness, and correctional clients.

Example 1: Resident 2

On 10/14/2025, at approximately 11:00 AM, Surveyor interviewed Resident 2 as s/he was interested in who the Surveyor was. Surveyor noted that as Resident 2 explained that s/he did not feel it was right that s/he was not allowed to hold his/her cigarettes his/her speech increasingly became more aggressive.

On 10/14/2025, Surveyor reviewed Resident 2's record.

Resident 2 moved into the home in 09/2021 and was his/her own person.

Resident 2's daily notes documented:
08/05/2025 - Was yelling all morning
08/23/2025 - When [s/he] awake, [s/he] came in the living [sic] started yelling back and fourth at another resident.
08/25/2025 - Member was up all night being rude to the other members while sleeping. Member kept trying to ride his bike all night. Member had a minor incident with another remember because [Resident 2] was yelling very loud waking the

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other members up so [Resident 3] hit [Resident 2] in the back of the head and started choking [him/her].
09/04/2025 - Standing in the living [sic] yelling but [s/he] did calm down after getting a cigarette.
10/09/2025 - [Resident 2] was constantly screaming and getting loud cause I had told [him/her] I had to make sure [his/her] vape was charged. In the mist of me giving [him/her] [his/her] shower, [s/he] spit on me twice cause I had told [him/her] it wasn't done charging.

Resident 2's unsigned ISP, dated 09/21/2023, documented:
Supervision: Needs some supervision
Self-Direction: Makes needs known; Needs Assistance
Capacity for Self-Care: Needs some assistance - Walker/Shower Chair
Aggressive/Combative: Left blank - no comment
Verbal: Left blank - no comment
Attitude Interaction With Others: Left blank - no comment

The ISP did not identify that Resident 2 had a restriction regarding the holding of his/her cigarettes and that s/he displayed verbal aggression.

On 10/14/2025, at approximately 11:40 AM, Resident 2 ambulated towards his/her room. Caregiver D asked him/her if s/he needed any assistance. Resident 2 aggressively answered Caregiver D stating s/he was going to take a nap, and s/he didn't need Caregiver D always asking him/her if s/he needed assistance.

On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Licensee B stated that staff had quit over

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M 424	Continued From page 11 Resident 2's verbal aggression. Licensee B stated s/he understood that a resident's ISP was to include individualized details regarding behaviors and possible restrictions. Example 2: Resident 3 On 10/14/2025, Surveyor reviewed Resident 3's record. Resident 3 moved into the home, 05/2022, and was represented by Guardian C. Resident 3's unsigned ISP was dated 05/28/2022. The ISP should have been updated in 11/2022, 05/2023, 11/2023, 05/2024, 11/2024, and 05/2025. On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Licensee B stated s/he would ensure all ISPs were updated every 6 months with the resident's care team and their signatures obtained.	M 424		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician.	M 462		

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M 462	Continued From page 12 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 3 residents' medications were administered as prescribed. Resident 2's medication administration record (MAR) was difficult to follow to determine if the prescribed Ferrous Sulfate (iron supplement) and Furosemide (diuretic) had been administered as prescribed. Findings include: On 10/14/2025, at approximately 11:15 AM, Surveyor observed Resident 2's blister card that contained Ferrous Sulfate and Furosemide, with a dispensed date of 09/26/2025 and a handwritten start date of 09/29/2025. Out of 30 bubbles, 12 bubbles remained. Of the 12 bubbles, only 5 contained Ferrous Sulfate. On 10/14/2025, Surveyor reviewed Resident 2's record. Resident 2 moved into the home 09/2021. Resident 2's MARs, dated 09/29/2025 to 10/14/2025, documented: Ferrous Sulfate 325 MG (milligram) - Take one tablet by mouth three times weekly. The MARs documented that the medication had been administered daily. The MAR did not identify which days of the week the medication was to be administered. Furosemide 20 MG - Take one tablet by mouth every morning. Scheduled at 8:00 AM. The MARs documented that the medication had been administered as prescribed.	M 462		

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M 462	Continued From page 13 Surveyor noted that if the blister card was started on 09/29/2025, 16 days' worth of medication should have been administered, leaving 14 available bubbles of medication. There were 12. Surveyor was unable to determine if the Ferrous Sulfide had been administered as prescribed. On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Licensee B stated s/he was confused by how the MAR was documented and how the medications did not correlate with the documented administration. Licensee B stated s/he would re-educate staff on proper medication administration and make sure the MARs were clear was to when a medication was to be administered.	M 462		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician who prescribed the medications,	M 464		

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M 464	Continued From page 14 specifying who by name or position was permitted to administer the medication for 2 of 2 residents reviewed (Resident 2 and Resident 3). Findings include: On 10/14/2025, Surveyor reviewed Resident 2's and Resident 3's record. Resident 2 moved into the home 09/2021. Resident 2's individual service plan, dated 09/2023, documented that medication administration was completed by staff. Resident 2's record did not contain a written order identifying who would be administering his/her medications. Resident 3 moved into the home 05/2022. Resident 3's individual service plan, dated 05/2022, documented that medication administration was completed by staff. Resident 3's record did not contain a written order identifying who would be administering his/her medications. On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Surveyor stated s/he was unable to locate the written orders in Resident 2's and Resident 3's record. Licensee B stated s/he was not aware this was a requirement, and s/he would obtain the written order when the resident's when to their next scheduled medical appointments.	M 464		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure	M 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017420	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST GRACE ASSISTING LIVING LLC	8945 W MILL ROAD MILWAUKEE, WI 53225

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M 482	Continued From page 15 location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain the records for 1 of 4 residents (Resident 1) reviewed, in a secure location within the home. Findings include: On 10/14/2025, at approximately 11:00 AM, Surveyor requested to review Resident 1's record from Licensee A and Licensee B. Licensee B stated s/he had been working on updating the resident records and could not determine if Resident 1's record was up to date. Licensee B stated Resident 1's file was not onsite.	M 482		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017420	A. BUILDING: _____ B. WING _____	10/14/2025

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M 570	Continued From page 16	M 570		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that the home was a safe environment and that residents were safeguarded from environmental hazards.

The clothes dryer had a flexible vent pipe, causing a possible fire hazard.
The laundry area had electrical wires hanging above the washer and sink area that were an obstruction.
The basement had a musty like scent and the walls contained a black mold like substance.

Findings include:

The provider was licensed to provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, physically disabled, developmentally disabled, advanced aged, terminally ill, emotionally disturbed/mental illness, and correctional clients.

Example 1: Dryer Vent

On 10/17/2025, at approximately 11:30 AM, Surveyor toured the home and observed the dryer, which was in the basement. Surveyor observed a foil accordion style vent tubing from residential clothes dryer to vent duct. The vent was not marked to determine if it met the Underwriters Laboratories (UL) guidelines.

"The codes require that dryer vents be made of metal with smooth interior finishes, sections of vent duct be securely supported and firmly sealed together, and the total length of the vent duct not exceed 35 feet (shorter if there are turns or bends). Flexible transition ducts used to connect the dryer to the exhaust system are required to

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M 570	Continued From page 17	M 570		

be not longer than 8 feet ... Flexible vents can twist, allowing lint to build up and catch on fire if it comes in contact with a sufficient amount of heat. ... Only flexible transition ducts that are listed by UL or another approved product safety testing agency should be used." (Source: The US Fire Administration - FEMA website, Clothes Dryer Fires in Residential Buildings (2008-1010), August 2012, https://www.usfa.fema.gov/downloads/pdf/statistics/v13i7.pdf (retrieval date - September 14, 2022).)

Example 2: Laundry Room Wires

On 10/17/2025, at approximately 11:30 AM, Surveyor toured the home and observed the laundry area, which was in the basement. Surveyor observed electrical wires hanging over the rafters, above the washing machine and sink. Surveyor noted that wires would need to be moved to close the washing machine. Surveyor was unable to determine what the wiring was for but that a staff member or resident could easily pull the wires down if they were not moved properly.

Example 3: Basement Walls

On 10/17/2025, at approximately 11:30 AM, Surveyor toured the home and observed the basement walls that contained a black mold like substance. Surveyor noted the basement had a musty like smell.

On 10/14/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A and Licensee B. Licensee A and Licensee B stated the concerns would be addressed.