STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019556	A. BUILDING: _____ B. WING _____	R-C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURTURING ADULT LIVING HOMES III LLC	1834 BLAKE AVE RACINE, WI 53404

(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 12/15/2025, Surveyors conducted a verification visit and 2 complaint investigations at Nurturing Adult Living Homes III. As a result, 10 of the previous 14 deficiencies were corrected, 4 deficiencies were recited, and 4 new deficiencies were identified, for a total of 8 deficiencies. One complaint was substantiated, and 1 complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census:1	{M 000}		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department, within 24 hours, when 1 of 1 resident (Resident 1) eloped and was later found by police. Findings include: On 12/11/2025, at 12:30 PM, Surveyors	M 134		

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

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M 134	Continued From page 1	M 134		

completed a review of the Department's facility file. Surveyors did not review any self-reports submitted to the Department in 2025.

On 12/15/2025, at 9:30 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/24/2023 with diagnoses including borderline personality disorder, oppositional defiant disorder, post-traumatic stress disorder, major depressive disorder and attention deficit hyperactivity disorder. Resident 1's individual service plan (ISP), dated 10/22/2023, under section "Supervision," stated: "Supervision required: Constant supervision required. Unsupervised independence in the community: Not appropriate. 24 hour one on one supervision."

Resident 1's ISP does not identify any elopement behaviors or interventions for staff to provide to Resident 1.

Surveyors reviewed emergency detention paperwork in Resident 1's file and identified the following:

- On 09/14/2025, at 7:00 AM, Resident 1 eloped from a vehicle driven by staff member. Resident 1 was located at 4:20 PM by police. Resident 1 reported s/he swallowed glass and attempted to get hit by traffic during elopement. Resident 1 was transported to the local hospital.

On 12/15/2025, at approximately 11:15 AM, Surveyors interviewed Licensee A. Licensee A reported s/he was unaware of the requirement to report to the department when a resident eloped. Licensee A reported s/he would complete required documentation and submit a self-report to the department

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{M 216}	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review, and interviews, the provider did not ensure the home, and its operation complied with this chapter and all other laws governing the home and its operations potentially affecting 1 of 1 resident. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations. This is a repeat deficiency. See Statement of Deficiency (SOD) RQ3S11, dated 02/25/2025. Findings include: On 12/15/2025, at 8:00 AM, Surveyors reviewed department files and identified the following: On 05/19/2025, the Department issued Statement of Deficiency RQ3S11 and Notice and Order Letter notifying the provider of the results of a standard survey at Nurturing Adult Living Homes III. As a result of the survey, the following 14 deficiencies were identified: M0204 88.03(8)(a) Monitoring of Home M0216 88.04(2)(a) Responsibilities M0232 88.04(2)(g)1 Health Screening for Staff M0244 88.04(5)(a) Training - 15 Hours Within 6 Months M0246 88.04(5)b Training - 8 Hours Annually	{M 216}		

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{M 216}	Continued From page 3 M0332 88.05(4)(a) Fire Safety - Fire Extinguishers M0346 88.05(4)(d)2.b Fire Evacuation Annual Evaluation M0348 88.05(4)(d)2.c Semi-Annual Fire Drills M0380 88.06(2)(a) Admission - Health Exam M0384 88.06(2)(b) Service Agreement Except Respite M0410 88.06(3)(d) Individual Service Plan M0420 88.06(3)(d)5 Signed Statement of Agreement M0458 88.07(3)(a) Prescription Medications M0464 88.07(3)(d) Medication- Written Order The Special Orders from the Notice and Order Letter included the following: " . . . ADDITIONALLY, The licensee shall review the training records for each service provider and ensure the following: - Each service provider employed at least 6 months will have completed all initial training as required by Wis. Admin. Code § DHS 88.04(5)(a). - Each service provider who may be exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions prior to assuming duties that may expose the service provider to such material, and annually. - Each service provider shall complete 8 hours of training 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. - Continuing education requirements must be met	{M 216}		

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{M 216}	Continued From page 4 for the licensee and all service providers, as appropriate, for calendar year 2024. All training required by Order #1 will be documented in employee records. Training records will include the date/duration of training, an outline of course content and documentation of successful completion of the training requirements. 2. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each resident with a copy of Statement of Deficiency RQ3S11 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request..." On 12/15/2025, Surveyors conducted a verification visit and 2 complaint investigations at Nurturing Adult Living Homes III. As a result, 10 of the previous 14 deficiencies were corrected, 4 deficiencies were recited, and 4 new deficiencies were identified, for a total of 8 deficiencies. One complaint was substantiated, and 1 complaint was unsubstantiated. The following deficiencies were identified: M0134 88.03(5)(e)1 Significant Change to The Resident M0216 88.04(2)(a) Responsibilities - This is a repeat cite M0232 88.04(2)(g)1 Health Screening for Staff -	{M 216}		

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{M 216}	Continued From page 5 This is a repeat cite M0244 88.04(5)(a) Training - 15 Hours Within 6 Months - This is a repeat cite M0346 88.05(4)(d)2.b Fire Evacuation Annual Evaluation - This is a repeat cite M0424 88.06(3)(f) Review of ISP M0570 88.10(3)(l) Safe Physical Environment M0610 88.11(1) Reporting of Abuse and Neglect On 12/15/2025, at 9:50 AM, Surveyors reviewed staff files and identified the following Caregiver D was hired on 07/13/2023. Caregiver D's record did not contain any evidence of annual training for 2024 as outlined in the special orders. Surveyors did not review any evidence a copy of SOD RQ3S11, or a copy of the Notice and Order Letter was provided to each resident, legal representative, and case manager (if any) as outlined in the special instructions. On 12/15/2025, at approximately 11:15 AM, Surveyors interviewed Licensee A. Licensee A reported s/he did not provide a copy of the SOD or Notice and Order Letter to all residents' case managers. Licensee A reported s/he was unaware of the requirement to send the documents to Resident 1's case manager and legal guardian. Licensee A reported s/he was unaware how to document and have staff complete training for the year 2024.	{M 216}		
{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	{M 232}		

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{M 232}	Continued From page 6 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers (Caregiver F) was screened for communicable diseases, including tuberculosis (TB), within 90 days before the start of providing cares. This is a repeat deficiency. See Statement of Deficiency (SOD) RQ3S11, dated 02/25/2025. Findings include: On 12/15/2025, at 9:50 AM, Surveyors reviewed Caregiver F's file. Caregiver F was hired on 12/07/2025. Caregiver F's record contained a TB skin test dated 02/13/2025, which was 297 days prior to start of cares. Caregiver F's record did not contain a communicable disease screening. On 12/15/2025, at approximately 11:15 AM, Surveyors interviewed Licensee A. Licensee A reported s/he believed Caregiver F's TB test was good for one year. Licensee A reported s/he was unaware Caregiver F's file did not contain a communicable disease screening.	{M 232}		

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{M 244}	Continued From page 7	{M 244}		
{M 244}	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 3 (Caregiver F and Caregiver G) caregivers reviewed received 15 hours of training related to health, safety and welfare, resident rights, first aid and fire safety, and treatment appropriate to residents prior to or within 6 months of starting to provide cares. This is a repeat deficiency. See Statement of Deficiency (SOD) RQ3S11, dated 02/25/2025. Findings include: Observations On 12/15/2025, at 9:05 AM, Surveyors entered the facility. Caregiver F and Resident 1 were the only individuals in the facility at the start of the survey. Record Review	{M 244}		

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{M 244}	Continued From page 8 On 12/15/2025, at 9:50 AM, Surveyors reviewed staff files and identified the following: - Caregiver F was hired on 12/07/2025. Caregiver F's record did not contain evidence of training related to health, safety and welfare, resident rights, first aid, fire safety, and treatment appropriate to residents. - Caregiver G was hired on 05/21/2025. Caregiver G's record did not contain evidence of training related to health, safety and welfare, resident rights, first aid, fire safety, and treatment appropriate to residents. Interview On 12/15/2025, at approximately 11:15 AM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirements. Licensee A confirmed Caregiver F did not have the required training prior to working alone. Licensee A confirmed Caregiver G's record did not contain training. Licensee A did not offer an explanation why Caregiver G's file did not contain any record of initial training.	{M 244}		
{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 2 minutes.	{M 346}		

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{M 346}	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 1 of 1 resident (Resident 1) who lived in the facility beyond one year. Resident 1 did not have an evacuation completed in 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) RQ3S11, dated 02/25/2025. Findings include: On 12/15/2025, at 9:30 AM Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/24/2023 with diagnoses including borderline personality disorder, oppositional defiant disorder, and post-traumatic stress disorder. Resident 1's record contained a Resident Evacuation Assessment, dated 08/23/2023. Resident 1's annual evacuation evaluation was due in August 2025. Resident 1's record did not contain an annual evacuation evaluation for August 2025. On 12/15/2025, at approximately 11:15 AM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirements. Licensee A confirmed s/he did not complete an annual evacuation assessment for Resident 1. Licensee A stated, "I forgot to do it, that's on me." Licensee A reported s/he would ensure the documentation was completed.	{M 346}		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months	M 424		

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M 424	Continued From page 10	M 424		

by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 1's) individual service plan (ISP) was reviewed and updated every 6 months and when Resident 1 had a change of condition. Resident 1's ISP was not updated to include behavior interventions and was not reviewed in April 2024, October 2024, April 2025 and October 2025.

Findings include:

On 12/15/2025, at 9:30 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/24/2023 with diagnoses including borderline personality disorder, oppositional defiant disorder, post-traumatic stress disorder, major depressive disorder and attention deficit hyperactivity disorder. Resident 1's Crisis Plan, dated 01/17/2024, indicated Resident 1 would ingest things, cut

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M 424	Continued From page 11	M 424		

herself/himself with sharp objects, run out in traffic, tie items around her/his neck, and make threats of self-harm or threats of harm towards others. The Crisis Plan indicated Resident 1 may experience some passive suicidal ideation and homicidal ideation at baseline. Coping skills for Resident 1 include journaling, listening to music, coloring, playing pranks, and talking care of her/his baby doll. The crisis plan indicated staff should maintain a calm and friendly demeanor.

Resident 1's ISP, dated 10/22/2023, reported the following:

"Emotional/Behavior - Delusions, combative or hallucinations. [Resident 1] states that [s/he] constantly hear [sic] voices which influence [her/him] to engage in self-harm behaviors.
Goals - Hallucinations will not be traumatic resulting in fearful reaction.
Interventions - One on one staff at all times to help reduce episodes of self harm [sic] behaviors."

"Emotional/Behavior - Delusions, combative or hallucinations. [Resident 1] has been hospitalized on several occasions due to self harming [sic] including cutting and trying to choke [herself/himself] with clothing items.
Goals - [Resident 1] will not harm [herself/himself]
Interventions - Anti-psychotic medications as directed as well as one on one supervision 24 hours a day to reduce episodes of self harming."

"Safety - High risk. [Resident 1] is at high risk for self harm [sic]. [S/He] has multiple episodes of choking and cutting [herself/himself].
Goal - Will be free from injury
Interventions - Constant supervision of staff."

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M 424	Continued From page 12	M 424		

"Combative behavior - [Resident 1] has a history of harming [herself/himself] and requires 24 hour supervision.
Goal - [Resident 1] will be free from injury.
Interventions - 24 hour one on one supervision to help prevent [Resident 1] from harming [herself/himself]."

Resident 1's record indicated Resident 1 had the following suicidal attempts:

01/06/2024 - ingestion of nontoxic substance
01/19/2024 - suicidal
03/20/2024 - swallowed foreign body
01/16/2025 - head injury, forehead abrasion, behavioral problem
04/11/2025 - swallowed glass, suicide attempt, emergency room visit
05/09/2025 - suicide attempt by cutting wrists, suicidal statements, police issued emergency detention to a mental health center
09/14/2025 - eloped from the house, swallowed foreign body, attempted to be struck by oncoming traffic, police issued emergency detention to a mental health center

Resident 1's crisis plan was dated 01/17/2024. Resident 1's ISP did not include interventions for staff to provide to Resident 1 when s/he was having passive suicidal and homicidal ideation. Resident 1's ISP did not mention Resident 1's Crisis Plan. Resident 1's record did not indicate Resident 1's ISP was reviewed in April 2024, October 2024, April 2025 and October 2025, or after any hospitalizations and emergency detentions.

On 12/15/2025, at 11:15 AM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he was

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M 424	Continued From page 13 aware Resident 1's ISP was not updated every 6 months and also did not include staff interventions for Resident 1's passive suicidal and homicidal ideations. Licensee A confirmed Resident 1's ISP did not reference her/his Crisis plan. Licensee A reported "we know it needs to be done; we have not gotten to it ...I have had a lot going on".	M 424		
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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment for 1 of 1 resident. The dryer vent was disconnected from the dryer. Findings include: On 12/15/2025, at 9:15 AM, Surveyors toured the home. Surveyors observed the laundry area located in the basement. The dryer vent was detached from the dryer and from the wall and was located on the floor. The wall behind the	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019556	A. BUILDING: _____ B. WING _____	R-C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURTURING ADULT LIVING HOMES III LLC	1834 BLAKE AVE RACINE, WI 53404

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M 570	Continued From page 14 dryer contained a material similar to lint. On 12/15/2025, at 9:30 AM, Surveyors interviewed Caregiver F. Caregiver F confirmed staff utilized the washer and dryer in the basement on Fridays. On 12/15/2025, at approximately 11:15 AM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirements. Licensee A reported s/he was unaware the dryer vent was detached from the dryer. Licensee A reported s/he would ensure the dryer vent was reattached.	M 570		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities. This Rule is not met as evidenced by:	M 610		

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M 610	Continued From page 15	M 610		

Based on record review and interview, the provider did not report abuse to the Department for 1 of 1 incident. Resident 1 was given a drink which contained Tetrahydrocannabinol (THC) by a staff member which resulted in hospital treatment.

Findings include:

On 11/21/2025, the Department received a complaint alleging Resident 1 was given a drink which contained an illegal substance.

Record Review

On 12/15/2025, at 9:30 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/24/2023 with diagnoses including borderline personality disorder, oppositional defiant disorder, and post-traumatic stress disorder. Resident 1's file contained an after visit summary, dated 11/05/2025, which indicated s/he "...tested positive for marijuana..." and the reason for visit indicated "shortness of breath and altered mental status".

Resident 1's file contained an incident report, dated 11/05/2025, which indicated "...[Resident 1] was brung [sic] to Ascension Hospital at 1:00 PM. S/he was took [sic] because owner [Licensee A] and staff [Caregiver C] had notice [sic] [Resident 1] had been acting different with slurred words and etc. S/he was given different tests and lab work to come out that s/he was tested positive for marijuana. [Resident 1] did tell the social worker of Ascension Hospital that it was given to her/him 3 times...[Caregiver G] was the person who have been given [sic] to her/him..."

On 12/16/2025, at 8:00 AM, Surveyors reviewed

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	0019556	A. BUILDING: _____ B. WING _____	R-C 12/15/2025

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M 610	Continued From page 16 Racine Police Department incident report and identified the following: - On 11/05/2025, at 9:26 PM, Racine Police were dispatched to the emergency room for reports of a group home worker giving a THC infused slushy to a resident. The report stated "...The owner of the group home [Licensee A] advised [Caregiver G] was giving THC infused in a slushy to her/his patient [Resident 1]. [Resident 1] advised this occurred more than two times at the group home. [Resident 1] states [Caregiver G] told her/him it would make her/him sleep better and told her/him it contained THC. Staff at the group home noticed [Resident 1] was acting different and became worried, then brought her/him to the hospital. [Resident 1] later tested positive for THC..." On 12/15/2025, at 11:15 AM, Surveyors interviewed Licensee A and Administrator I. Licensee A reported s/he fired Caregiver G on 11/05/2025, the day the incident occurred. Surveyors requested any investigation documentation regarding incident involving THC for Resident 1 and Caregiver G. Licensee A reported the only documentation they had was the incident report. Licensee A confirmed s/he did not conduct an investigation. Licensee A reported s/he was unaware of the reporting requirement timeline. Administrator I reported s/he did not submit a report because s/he did not receive the police report. Administrator I then reported s/he tried to submit the report but was unsure how to submit it due to problems with the system. Licensee A and Administrator I reported a self-report would be completed and submitted to the Department.	M 610		