STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018106	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ITS ABOUT YOU ADULT FAMILY HOME LLC	1716 HARRISON AVENUE BELOIT, WI 53511

(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 From 04/29/2026 through 05/18/2026, Surveyor conducted a complaint investigation at Its About You Adult Family Home LLC. Two deficiencies were identified. The complaint was substantiated. Census: 3	M 000		
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 observations, record review and interview, the provider did not ensure 1 of 2 residents' (Resident 1) Individual Service Plan (ISP) included all required information. Resident 1's ISP did not identify behaviors and smoking schedule. Findings include: On 04/08/2026, the department received a complaint alleging a resident was mistreated in the facility. On 04/29/2026, Surveyor conducted a complaint investigation and requested resident records from Caregiver A. Resident 1 was admitted on 07/22/2024 with	M 410		

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

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M 410	Continued From page 1	M 410		

diagnoses including major depressive syndrome, schizoaffective disorder and anxiety. Resident 1's ISP with an unknown date did not identify his/her behaviors related to verbal/physical aggression, smoking schedule, smoking inside his/her bedroom and refusals of bathing and cleaning room.

Resident 1's observation notes indicated the following:

-03/03/2026 1:15 p.m., "I asked [Resident 1] to take a shower-before I took [resident] to [appointment]- [s/he] said [s/he] would - then while I was gone [s/he] left - did not take a shower- has a very strong odor of BM - and wearing same clothes [s/he] had on yesterday- [s/he] also smelled of BM yesterday too."
-03/18/2026 10:45 a.m., "[Resident 1] was asked to change [his/her] depends - [s/he] had a fowl order and was trying to go to work that way."
-03/23/2026 12:15 p.m., "I removed a lge (sic) bag o f (sic) tobacco and rolling papers from [Resident 1]'s room today and put smoke detector back up."
-03/25/2026 10:15 a.m., "smoke detector on floor in [Resident 1's] room."
-03/27/2026 2:30 p.m., "[Resident 1] left for Lacrosse and did not take a shower -also left a bucket full of depend full of Bm."
-03/30/2026 12:15 a.m., "from downstairs in the basement I can hear [Resident 1] playing [his/her] guitar in [his/her] room and [his/her] lights are on."
-03/31/2026 10:45 a.m., "I was informed when I arrived to work at 6:45 that [Resident 1] had been up since 5:00 am making all kinds of noise - playing music loud- [s/he] woke up another resident that had to got to work early in the morning. After breakfast [s/he] asked if [s/he] could smoke and I told [him/her] after [s/he]

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M 410	Continued From page 2	M 410		

cleaned [his/her] room -[s/he] chose to get in the cabinet and get the smokes [himself/herself]. When [s/he] came back in the home [s/he] chose to make [himself/herself] a cup of coffee. [S/he] has not had a shower since who knows when -always smells of BM-does not wash [his/her] hands. Very rude. When [his/her] [caseworker] came [s/he] told me that [s/he] didn't want me in [his/her] conversation- I replied to [him/her] that [s/he] was not the boss here and [s/he] wasn't going to keep trying to bully me. [S/he] chose to slam the table with [his/her] fist so hard the coffee cup flew off the table and made a mess- called me a [profanity] and said [s/he] was ready to smash something. I did call the police on [him/her] at this point because [s/he] had all the other residents of the home very upset."

On 04/29/2026 at approximately 12:35 p.m., Surveyor interviewed Caregiver D. Caregiver D stated that Resident 1 did have some behavioral problems and did refuse to shower for many of the staff in the home. Caregiver D stated that Resident 1 kept his/her cigarettes and lighter in the med cabinet but would forget to turn the items in. Caregiver D said that Resident 1 attended [community program] at least 1 time a week. Surveyor noted that it was not documented in the ISP.

On 04/29/2026 at approximately 1:00 p.m., Surveyor interviewed Caregiver A. Caregiver A reported Resident 1 was very demanding. Caregiver A stated that Resident 1 refused showers and would leave the facility very dirty. Caregiver A stated that the facility kept all of Resident 1's cigarettes locked in the locked med cabinet and would pass them out to Resident 1 every couple of hours. Caregiver A stated that there was not a posted schedule and sometimes

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M 410	Continued From page 3 Caregiver A gave Resident 1 his/her allotted cigarettes for the day to decrease problems. Caregiver A stated that Resident 1 was often verbally aggressive towards staff and would slam fists on property. Caregiver A stated that Resident 1 refused showers and would leave the facility very dirty. Caregiver A stated that Resident 1 had been caught smoking in his/her room a couple times. Caregiver A stated that Resident 1 would remove the smoke alarm and open the window. Caregiver A stated that Resident 1's room was always very messy, and s/he refused to clean the room. Caregiver A stated that s/he does try to track on the Resident 1's behaviors on the tracker but the computer system loses stuff sometimes. On 05/18/2026 at 3:25 p.m., Surveyor interviewed Licensee A regarding the above concern. Licensee A acknowledged that Resident 1's behavior of verbal aggression, smoking schedule, concerns with smoking in the home and refusals to clean himself/herself were not included in the ISP. Licensee A confirmed Resident 1 had displayed the above behaviors since moving to the facility. Licensee A reported that Resident 1 had moved out of the facility. Licensee A stated s/he would update the other resident ISP's.	M 410		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on record review and interview, Resident 1	M 548		

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M 548	Continued From page 4 was not treated with courtesy, respect and full recognition of his/her dignity and individuality. Findings include: On 04/08/2026, the department received a complaint alleging a resident was mistreated in the facility. On 04/29/2026, Surveyor conducted a complaint investigation. The provider is an AFH licensed to serve up to 4 residents with primary diagnoses of emotionally disturbed/mental illness, physically disabled and developmentally disabled. Surveyor requested records for Resident 1. Resident 1 was admitted on 07/22/2024 with diagnoses including major depressive syndrome, schizoaffective disorder and anxiety. Resident 1's individual service plan (ISP) with an unknown date did not identify his/her behaviors related to verbal/physical aggression, smoking schedule, smoking inside his/her bedroom and refusals of bathing and cleaning room. Resident 1's observation notes indicated the following: -04/04/2026 12:15 a.m., "[Resident 1] has not turned in [his/her] cellphone at 12:00 pm. I didn't ask for it and [his/her] bedroom light is still on." -04/01/2026 10:45 a.m., "Resident 1] is not turning in [his/her] lighter at night. [Resident 1]'s room is a disaster -you can't even walk on [his/her] floor. -03/31/2026 10:45 a.m., "I was informed when I arrived to work at 6:45 that [Resident 1] had been up since 5:00 am making all kinds of noise - playing music loud- [s/he] woke up another	M 548		

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M 548	Continued From page 5 resident that had to got to work early in the morning. After breakfast [s/he] asked if [s/he] could smoke and I told [him/her] after [s/he] cleaned [his/her] room -[s/he] chose to get in the cabinet and get the smokes [himself/herself]. When [s/he] came back in the home [s/he] chose to make [himself/herself] a cup of coffee. [S/he] has not had a shower since who knows when -always smells of BM-does not wash [his/her] hands. Very rude. When [his/her] [caseworker] came [s/he] told me that [s/he] didn't want me in [his/her] conversation- I replied to [him/her] that [s/he] was not the boss here and [s/he] wasn't going to keep trying to bully me. [S/he] chose to slam the table with [his/her] fist so hard the coffee cup flew off the table and made a mess- called me a [profanity] and said [s/he] was ready to smash something. I did call the police on [him/her] at this point because [s/he] had all the other residents of the home very upset." -03/23/2026 12:15 p.m., "I removed a lge (sic) bag o f (sic) tobacco and rolling papers from [Resident 1] room today and put smoke detector back up." -03/20/206 2:30 p.m., " ...[Resident 1] was talking [expletive word] ato (sic) me because I told [him/her] Infront of [manager] [s/he] to turn in [his/her] lighter and [s/he] said [expletive] no and [s/he] said [s/he] isn't doing that ...came back in for meds also ask to turn in [his/her] cigars and lighter [s/he] just walk in [his/her] room and ignore me." -03/18/2026 8:30 p.m., "got home from aaa smelled really bad his pants were full of pop (sic) didn't want to shower I told [s/he] couldn't sit in the kitchen with out talking a shower [s/he] went in the shower the bathroom was a mess after [his/her] shower." -02/26/2026 9:45 p.m., " ...I'm not turning in my phone and is [Licensee B] takes my phone Ill	M 548		

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break this [expletive] TV -Im tired of this [expletive] group home and these [expletive] rules ..."
-02/19/2026 12:15 p.m., "[Resident 1] went to AA -search of [his/her] room -came up with 3 lighters."
-02/12/2026 10:15 a.m., "[Resident 1] was up all night- [s/he] did not turn in [his/her] phone last night -[s/he] was up talking on it."

Surveyor noted that Resident 1's items were being locked up and taken away from him/her as indicated in the progress notes and was not documented in the ISP that staff had access to on the computer in the facility.

On 04/29/2026 at 12:40 p.m., Surveyor interviewed Caregiver D. Caregiver D stated that the facility was locking up [Resident 1's] cigarettes and lighters for the safety of the home. Caregiver D stated that [Resident 1] was also supposed to turn in his/her phone because s/he would disrupt the house with it. Caregiver D did not know if there was a plan for the cigarettes or phone but said that all the staff knew about locking these items up. Caregiver D stated that [Resident 1] would get upset about turning in his/her items to some of the staff. Caregiver D stated that s/he did not usually have any problems with [Resident 1] turning in these items.

On 04/29/2026 at 12:57 p.m., Surveyor interviewed Caregiver A. Caregiver A stated that s/he did not restrict cigarettes from [Resident 1]. Caregiver A stated that s/he did ask [Resident 1] to shower first. Caregiver A stated that after the incident on 03/31/2026, s/he just gave [Resident 1] all of his/her cigarettes in the morning so that there were no issues. Caregiver A stated that s/he knew [Resident 1's] plan was in the computer but

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M 548	Continued From page 7 did not know if the plan mentioned anything on how to handle cigarettes or phone. Caregiver A stated that s/he and the other staff members had problems with getting [Resident 1] to turn in his/her items and that s/he had to check [Resident 1's] room for smoking materials. Caregiver A stated that on 03/31/2026, s/he did take the [agency] staff to the [Resident 1's] room and showed him/her that is was a fire hazard. Caregiver A said s/he told [agency] staff what was going on with [Resident 1] in the home with his/her behaviors and having BM on himself/herself. On 05/11/2026 at 2:08 p.m., Surveyor interviewed Quality Assurance RN C. Quality Assurance RN C stated that the staff in the home had treated [Resident 1] disrespectfully. Quality Assurance RN C stated that Caregiver A talked about not giving cigarettes until [Resident 1] showered and stated that [Resident 1] always smelled of BM. Quality Assurance RN C stated that [Resident 1] was not treated with dignity on 03/31/2026. On 05/18/2026 at 3:08 p.m., Surveyor shared the above concerns with Licensee B regarding treating Resident 1 respectfully and not locking his/her items up. Licensee B acknowledged that [Resident 1] was a difficult resident and had moved out. Licensee B stated that the facility locked up the items due to Resident 1 breaking the rules of the home. Licensee B acknowledged that the care plan at the facility did not review the concerns regarding the smoking materials or phone. Resident 1 was not treated with courtesy, respect and full recognition of his/her dignity and individuality.	M 548		