STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017553	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A+ JUST LIKE FAMILY FRANKLIN A	1619 FRANKLIN ST A MOUNT PLEASANT, WI 53403

(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 02/25/2026, Surveyor concluded one complaint investigation at A+ Just Like Family Franklin A. Three deficiencies were identified. One complaint was substantiated. Census: 3	M 000		
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 there were	M 262		

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

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M 262	Continued From page 1	M 262		

two ramped to grade exits from the facility for 1 of 1 resident who utilized a wheelchair for mobility. The back door had a 1 ¼ inch rise to exit the facility. Resident 2 utilized a wheelchair and self-propelled for mobility.

Findings include:

On 02/20/2026, between 10:00 a.m. and 3:30 p.m., Surveyor toured the facility and observed the following:
- The back door exited to an outside patio area of the Adult Family Home.
- The back door had a 1 ¼ -inch rise to exit the facility.
- Resident 2 self-propelled in his/her wheelchair for mobility.
- The posted exit plan identified two emergency exits; one was at the back door of the facility.
- Surveyor observed Resident 2 independently utilized the back door to go outside to smoke.

On 02/20/2026, at 2:15 p.m., Surveyor reviewed resident records and identified the following:
-Resident 2 was admitted on 11/13/2023. Resident 2's Individual Service Plan (ISP), dated 11/04/2025, indicated Resident 2 utilized a wheelchair for mobility.

On 02/20/2026, at 10:22 a.m., Surveyor interviewed Supervisor B who confirmed Resident 2 utilized a wheelchair for mobility.

On 02/20/2026, at 1:45 p.m., Surveyor interviewed Resident 2 regarding the back door exit. Resident 2 stated, "There is a bump I have to get over."

On 02/20/2026, at 2:45 p.m., Surveyor interviewed Supervisor B, who confirmed the

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M 262	Continued From page 2 home was non-ambulatory. Supervisor B acknowledged the back door not being ramped to grade and stated, "I told them that would be an issue."	M 262		
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 record review and interview, the provider did not ensure 1 of 1 resident Individual Service Plans (ISP) were updated when the resident's needs had changed. Resident 1's original ISP was dated 02/08/2025 and was not updated following her/his elopements on 06/28/2025, 08/31/2025 and 01/10/2026. On the night of 01/27/2026 to 01/28/2026, Resident 1 eloped and was located by Racine County Police Department (RC-PD) with frost on his/her hair	M 424		

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M 424	Continued From page 3	M 424		

and injuries to his/her right hand from the cold. Resident 1 wandered away from the home without staff knowledge.

Findings include:

Resident 1 was admitted on 04/19/2023 with diagnoses including memory impairment, severe arthritis, and impaired mobility. Resident 1 had a guardian. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 1's individual service plan (ISP) dated 02/08/2025 indicated Resident 1 required 24-hour supervision in the home.

Resident 1's ISP, dated 02/08/2025, identified the following:

General Questions
Supervision: 24-hour supervision.
Capacity for self-care: Needs total assistance.
Capacity for self-direction: Needs assistance.

Resident 1's ISP form was divided into several categories including activities of daily living (ADLs), instrumental activities of daily living (IADL's), Medication Administration, Behavior Patterns, Physical Health, Mental Health, Social Participation, and Independent Living Skills.

Surveyor noted the following section:
Elopement risk. (Behavior patterns/Wandering Risk).
-Directions: Provide supervision and redirection to avoid and prevent elopement. Provide checks throughout day/night and document whereabouts. Follow elopement procedures. Ensure door alarms are on and working properly.
-Schedule: Daily at night, morning, afternoon,

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evening, as needed.
-Resident's needs/preferences: Require supervision and redirection from staff to prevent elopement episodes. Exit seeking and require checks throughout day/night.
-Resident's desired goals and outcomes: To have proper precautions and redirection techniques in place to prevent elopement.
-Service provider responsibilities: Staff

Surveyor observed Resident 1's updated ISP, dated 01/28/2026, the dated Resident 1 came home from the hospital.

Surveyor reviewed Resident 1's incident reports. Resident 1 eloped on 06/28/2025, 08/31/2025 and 01/10/2026. Provider did not update the ISP to reflect changes in condition after the three elopements. Resident 1 eloped on 01/27/2026-01/28/2026. Resident was located outdoors, in the cold, with frostbite on his/her hair and injuries to his/her right hand from the cold.

Supervisor B stated s/he received a telephone call from the RC-PD at approximately 4:30 a.m. The officer asked him/her if s/he was aware that one of the residents was missing and was at the hospital. Supervisor B was unaware that Resident 1 had eloped. Supervisor B confirmed, "Nobody was able to confirm how Resident 1 got out."

On 02/20/2026, at 3:10 p.m., Surveyor interviewed Licensee A and asked why they waited until 01/28/2026 to updated Resident 1's ISP, after elopements on 06/28/2025, 08/31/2025 and 01/10/2026. Licensee A stated s/he did not implement a new assessment or a new ISP after the elopements because, "We do it every 6 months."

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M 424	Continued From page 5 Cross Reference: M0434 DHS 88.07(1)(e) Supervision	M 424		
M 434	88.07(1)(e) Supervision The licensee shall arrange for a service provider to be present in the home when the licensee is gone overnight or when the licensee's absence prevents the resident from receiving the services, training or supervision specified in the resident's individual service plan under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not arrange for a caregiver (service provider) to be present in the home when a resident required services or supervision. The licensee shared staff between two provider homes and did not ensure the provider's home was staffed when 1 of 3 residents (Resident 1) required 24-hour supervision. Findings include: On 02/06/2026, the department received a complaint that on 01/28/2026, a resident was located by Racine County Police Department (RC PD) with frost on his/her hair and injuries to his/her right hand from the cold. Definition of "Continuous care" from DHS 88 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	M 434		

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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 02/20/2026, between 10:00 a.m., and 3:30 p.m., Surveyor observed the following:

- The home was located on the north end of a side-by-side duplex style building. The building had 2 licensed Adult Family Homes (AFHs), owned by Licensee A and operated by Supervisor B. They are defined by Side A (this facility) and Side B (the licensed AFH next door).

Resident 1 was admitted to this facility on 04/19/2023 with diagnoses including memory impairment, severe arthritis, and impaired mobility. Resident 1 had a guardian. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 1's individual service plan (ISP), dated 02/08/2025, indicated Resident 1 required 24-hour supervision in the home.

On 02/20/2026 at 11:21 a.m., Surveyor reviewed Resident 1's, "1st, 2nd & 3rd Shift Daily Notes." Under, "3rd" shift, Surveyor observed Caregiver D's initials. The shift daily report had fill-in boxes for staff documentation. Under, "Where is resident? What are they doing? 3RD SHIFT TO DO 1HR CHECK." There was no documentation in box. Under, "Where is Resident? What are they doing? Any Issues or Concerns? 3RD SHIFT TO DO 1HR CHECK." The 01/27/2026 to 01/28/2026 shift daily notes were documented from 5:30 a.m. to 8:00 a.m., Resident 1 was at the hospital.

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Surveyor reviewed Resident 1's incident reports. The following was identified:

-On 01/10/2026 at 8:30 p.m., Caregiver F documented Resident 1 needed redirection most of the evening. Caregiver F was assisting another resident and Resident 1 exited out the back door. Caregiver F followed Resident 1 to the end of the block. Caregiver F stated, "I couldn't go any further due to other residents in the home. I called the director on call ...non-emergency staff brought Resident 1 home at 8:50 p.m."

-On 08/31/2025 at 3:10 p.m., Caregiver G documented Resident 1 was pacing from A+ Just Like Family adult family home (AFH) side A to A+ Just Like Family AFH side B. Caregiver G described Resident 1 as, "confused and agitated." Caregiver G reported one of the times Resident 1 was pacing over to Side B, while s/he cooked dinner, Resident 1 went out the front door instead. Caregiver G wrote, "Staff redirected but [sic] continued walking [sic] staff kept trying to redirect s/he continued walking [sic] took staff 15-20 minutes to get him/her home."

-On 06/28/2025 at both 12:00 p.m.-1:30 p.m. and 3:00 p.m.-3:30 p.m., Caregiver H documented Resident 1 eloped. Caregiver H stated, "S/He eloped and came back s/he walked up and down 16th street looking for a "deer foot that his/her dad gave to him/her."

Resident 1's hospital after visit summary, dated 01/28/2026, stated, "Reason for visit: Cold exposure. Diagnoses: Fall, initial encounter. Cold exposure, initial encounter."

Resident 1's after visit summary from wound care clinic on 02/03/2026 stated, "Reason for visit:

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M 434	Continued From page 8 Wound Care." Resident 1's after visit summary from family medicine clinic on 02/11/2026 stated, "Reason for visit: frostbite of right hand." On 02/20/2026, Surveyor reviewed an Adult Protective Services (APS) report, dated 02/02/2026. Adult Protective Services investigator (APSI) K wrote, "It was reported that on 1/28/2026, law enforcement located [Resident 1] with frost on his/her 'face' and injuries to his/her right hand from the cold. It was learned that s/he wandered from [Side A]. The staff did not know how or when [Resident 1] got out, and the staff member who was in charge of monitoring him/her was nowhere to be found. Per reporter, [Resident 1] was not allowed to leave on his/her own, and s/he is to be constantly monitored." On 02/17/2026, Racine Police Department provided department with incident report number 26-006775. The report outlined an interaction between RC-PD and Caregiver E on 02/11/2026. Police Officer (PO) J documented discussing the incident that occurred on 01/28/2026 with Caregiver E. PO J wrote, "Ultimately, [Caregiver E] explained that s/he no call no showed to work after stating s/he was going to be late and did not know why staff members stated s/he was at work that night." On 02/20/2026 at 10:20 a.m., Surveyor interviewed Supervisor B, who stated Side A had one caregiver and three residents. The first shift was from 8:00 a.m. to 4:00 p.m., the second shift was 4:00 p.m. to 11:00 p.m. and the third shift was 11:00 p.m. to 8:00 a.m. Supervisor B stated Saturdays and Sundays were 12-hour shifts.	M 434		

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Supervisor B stated Side B (next door AFH) had two caregivers and four residents. One resident (Person L) had dedicated 1:1 staffing, 24 hours a day. The first shift was from 8:00 a.m. to 4:00 p.m., the second shift was 4:00 p.m. to 11:00 p.m. and the third shift was 11:00 p.m. to 8:00 a.m. Supervisor B stated Saturdays and Sundays were 12-hour shifts.

Supervisor B explained on 01/27/2026, Caregiver I worked second shift on Side A from 4:00 p.m. to 11:00 p.m. Caregiver E was due to come in and work 11:00 p.m. to 8:00 a.m. at Side A. Caregiver E called Caregiver D on Side B and asked him/her to cover the shift until s/he arrived. Caregiver D agreed to cover his/her shift and dismissed Caregiver I from Side A. Caregiver D went over to Side A. Caregiver C was assigned to be the 1:1 staff for Person L from 11:00 p.m. to 8:00 a.m. on 01/27/2026 in the other AFH. Caregiver E did not show up to his/her shift. Caregiver D and Caregiver C did not notify management about staffing shortage.

Supervisor B stated s/he received a telephone call from the RC-PD at approximately 4:30 a.m. The officer asked him/her if s/he was aware that one of the residents was missing and was at the hospital. Supervisor B was unaware that Resident 1 had eloped.

Supervisor B confirmed, "Nobody was able to confirm how Resident 1 got out of the building."

On 02/20/2026 at 11:30 a.m., Surveyor interviewed Licensee A who stated the RC-PD contacted him/her to inform him/her that Resident 1 was missing. Licensee A called Side A and Side B, and that was when the caregivers realized Resident 1 was gone. Licensee A stated, "They

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are supposed to do room checks." Licensee A confirmed APS was at Side A last week and substantiated their complaint for lack of staff.

On 02/20/2026 at 12:05 p.m., Surveyor interviewed Supervisor B, while looking at Resident 1's hands. S/He stated the hospital did not initially say Resident 1 had frost bite on his/her hands. However, a couple days later, his hands and fingers began to blister. Supervisor B stated they had to take him/her to a clinic to be seen again for the blisters.

On 02/20/2026 at 12:50 p.m., Surveyor observed Resident 1's hands to be red, peeling, and scabbed. Surveyor interviewed Resident 1 about his/her hands. Resident 1 stated, "They are so cold." Supervisor B, who sat nearby stated, "They said that might be a side-effect of the frost bite."

On 02/25/2026, Licensee A emailed Surveyor and stated, "Attached is the report I will send to caregiver misconduct."
The document read, "[Caregiver E], informed [Caregiver D] that s/he would be late. On 2/27/2026. [sic]

- [Caregiver D] allowed the on-duty staff to leave [sic] and s/he would watch A side until [Caregiver E's] arrival.

- At midnight, [Caregiver D] returned to B Side and signed [Caregiver E] in, believing s/he had arrived since s/he heard and saw his/her loud vehicle outside.

- At 5:00 AM, [Caregiver D] received a call from the director inquiring if all residents were present. Upon checking, s/he discovered that [Resident 1] was missing.

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M 434	Continued From page 11 - The director informed dispatch regarding the missing resident, calling back home shortly after at 5:05 AM. - [Caregiver D] reported that s/he had spoken to [Caregiver E], who supposedly went to look for [Resident 1], but later clarified that [Licensee A] misunderstood the conversation, realizing that [Caregiver E] had never actually shown up for his/her shift. S/He stated that s/he heard his/her vehicle due to him/her having loud exhaust and seeing the lights pull into the driveway, but s/he did not see him/her physically enter the building s/he just assumed s/he did. [Caregiver D] stated s/he really thought [Caregiver E] was there. - [Resident 1] was taken to the emergency room on 2/28/26 [sic] due to blisters on hands and swelling on knuckles. - [Caregiver D] was told not to return to work on 2/28/2026 [sic] at 2:21 p.m. after investigation confirmed s/he left A side prior to having someone relieve him/her in person. Our policy states staff is to stay until they are relieved by relieving staff member." Surveyor noted the emailed information, and dates were inconsistent with collected documentation.	M 434		