STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013579	A. BUILDING: _____ B. WING _____	R-C 10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEY HOME I	N5668 - 884TH ST ELK MOUND, WI 54739

(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 10/08/2025, Surveyor conducted a verification visit and complaint investigation at Journey Home I. Data was collected through 10/13/2025. The complaint was unsubstantiated. Four violations were identified. Three of 4 violations were repeat deficiencies. See Statement of Deficiencies (SOD) CR4K11, dated 10/14/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 2	{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 ensure the Department was notified within 24 hours when a resident experienced a significant change in status. This is true for 2 of 2 incidents reviewed: Resident 1 fell on 07/28/2025 and was hospitalized for injuries;	M 134		

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

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M 134	Continued From page 1 and Resident 2's whereabouts were unknown between June and July 2025. Findings include: On 10/08/2025, Surveyor reviewed the provider's correspondence with the Department. The provider had not submitted any self-reports to the Department since licensure (2011). RESIDENT 1 On 10/08/2025 at 8:45 AM, Surveyor interviewed Licensee A. Licensee A stated Resident 1 fell outside, was sent to the emergency department, and hospitalized for 4 days in July. Licensee A stated Resident 1 was sent out due to being in pain and concern that s/he experienced heat exhaustion. Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/07/2023. An after-visit hospital summary report dated 08/01/2025 indicated Resident 1 was hospitalized on 07/28/2025 through 08/01/2025 for the following conditions: contusion buttock initial, anemia posthemorrhagic acute, contusion left upper arm initial, and fracture scapula closed initial right. At 9:20 AM, Surveyor asked Licensee A if s/he reported the incident to the Department. Licensee A stated, "I had no clue about that (self-reporting requirements)... no one ever told me that." RESIDENT 2 On 10/08/2025 at 8:45 AM, Surveyor interviewed Licensee A. Licensee A stated Resident 2 moved to the facility in February 2025 under guardianship. Licensee A said Resident 2's goal was to live independently. Licensee A shared that	M 134		

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M 134	Continued From page 2 Resident 2 had left the facility "for a few days" and ended up in a homeless shelter. Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 02/13/2025. His/her individual service plan (ISP), dated 04/07/2025, indicated Resident 2 required supervision: "Resident will be supervised overnight by providers or substitute providers who are at least 18 years of age and have an up to date criminal background check on record with Inclusa." The ISP indicated Resident 2 could have some unsupervised time, but it did not indicate how long. The ISP indicated Resident 2 required transportation, medication, and health monitoring services from the provider. Resident 2's record did not include documentation indicating when Resident 2 left the facility. At 11:57 AM, Surveyor interviewed Licensee A. Licensee A stated s/he reviewed billing documentation, and based on this, s/he believed Resident 2 was gone from the home from 07/28/2025 through 07/31/2025. Surveyor reviewed Resident 2's medication administration record (MAR) which indicated Resident 2 received medication services between 07/28/2025 through 07/31/2025; however, the following dates were crossed out on the MAR: 06/27/2025 through 07/07/2025 (11 days). At 12:05 PM, Surveyor asked Licensee A why the dates were crossed out on the MAR. Licensee A stated, "[Resident 2] had to be gone." Licensee A stated s/he believed Resident 2 was also gone between 07/28/2025 through 07/31/2025, but s/he could not explain why the MAR indicated s/he	M 134		

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M 134	Continued From page 3 received medications on these dates. Licensee A did not have record of incidents involving Resident 2. Licensee A stated s/he recalled that Resident 2 wanted to go to the mall. Licensee A stated s/he dropped Resident 2 at the mall and Resident 2 left with someone. Licensee A stated, "When [s/he] left with the ride, I didn't know where [s/he] went." Licensee A could not recall dates or additional details. Licensee A stated Resident 2 ended up in a homeless shelter before returning to the facility. Licensee A stated s/he notified Resident 2's guardian immediately, and Resident 2's guardian told Licensee A that Resident 2 had the right to leave.	M 134		
{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 interview, the licensee did not ensure the home and operation complied with laws and regulations. Licensee A did not comply with Department orders. This is a repeat violation. See Statement of Deficiency (SOD) CR4K11, dated 10/14/2024. Findings include: On 12/09/2024, the Department issued SOD CR4K11 with the following enforcement orders: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT	{M 216}		

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{M 216}	Continued From page 4 OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Journey Home I: 1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.b., EFFECTIVE IMMEDIATELY, the licensee shall ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. WITHIN 45 DAYS of receipt of this notice, the licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) CR4K11 ... WITHIN 45 DAYS of receipt of this notice, the licensee will provide training to all service providers on the corrective actions taken to resolve each deficient practice identified in SOD CR4K11. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training. 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 CR4K11 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."	{M 216}		

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{M 216}	Continued From page 5 On 10/08/2025, Surveyor requested evidence that the provider completed their enforcement orders from Licensee A. At approximately 9:40 AM, Licensee A provided handwritten notes indicating s/he sent the Notice and Order letter to 3 guardians. The notes indicated s/he sent the letter to the guardians via fax on 02/20/2025 and 02/21/2025, over 2 months after the SOD was issued. Licensee did not retain acceptable documentation that the Notice and Order letter was sent. Surveyor asked Licensee A if s/he sent a copy of the SOD also. Licensee A guessed that s/he did. Licensee A confirmed s/he did not send anything to the 3 case managers and that s/he did not send the documentation to the guardians within 7 days as required. At approximately 10:40 AM, Surveyor reviewed training records for the 2 staff (Caregiver B and Caregiver C) employed at the facility. Neither of the records included evidence of a training on the corrective actions taken to resolve each deficient practice identified in SOD CR4K11. At approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A confirmed s/he did not develop or provide training to staff on measures to correct the deficiencies identified in the previous survey.	{M 216}		
{M 458}	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as	{M 458}		

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{M 458}	Continued From page 6 specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure prescription medications were securely stored in the home. This is a repeat violation. See Statement of Deficiency (SOD) CR4K11, dated 10/14/2024. Findings include: On 10/08/2025 at 9:26 AM, Surveyor requested to see the provider's medication storage. Licensee A retrieved a key from an unlocked kitchen cabinet and opened the medication closet. Surveyor reviewed the medication storage and observed Licensee A return the key to the unlocked cabinet. Surveyor asked Licensee A where s/he stored the key when it was being used. Licensee A stated s/he had always kept the key to the medication closet in the unlocked cabinet. Licensee A stated, "Nobody told me to move it."	{M 458}		
{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	{M 464}		

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{M 464}	Continued From page 7 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 ensure they obtained written orders for medications they administered to 1 of 1 sampled residents (Resident 1). This is a repeat violation. See Statement of Deficiency (SOD) CR4K11, dated 10/14/2024. Findings include: On 10/08/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/07/2023. Resident 1's October medication administration record (MAR) indicated Licensee A administered the following medication to Resident 1 on a daily basis: - Metoprolol Succ ER 12.5 mg at 8 AM - Melatonin 2 mg at 8 PM - Lisinopril 5 mg at 8 AM - Jardiance 10 mg at 8 AM - Donepezil HCL 10 mg at 8 PM - Clopidogrel 75 mg at 8 AM - Atorvastatin 40 mg at 8 PM - Aspirin 81 mg at 8 AM Resident 1's record did not include written orders from the physician for each medication and dosage.	{M 464}		

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{M 464}	Continued From page 8 On 10/08/2025 at 12:34 PM, Licensee A stated, "I don't have med orders on file. I didn't know I needed them."	{M 464}		