

Wisconsin Department of Health Services

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|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0020868</b>           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/14/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JONES FAMILY CARE</b> |                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>824 N 17TH ST<br/>SHEBOYGAN, WI 53081</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                 | ID<br>PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| M 000                                                        | <p><b>INITIAL COMMENTS</b></p> <p>On 01/14/2026, Surveyors conducted a monitoring visit at Jones Family Care, for a request to amend ambulation status. As a result of the visit, the facility remains ambulatory only.</p> <p>Census: 4</p> | M 000                                                                                 |                                                                                                                          |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE