Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010451	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR FAMILY HOME	**425 ABRAMS ST GREEN BAY, WI 54302**

(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 10/22/2024, Surveyor conducted an abbreviated survey at Our Family Home. As a result of the survey, 1 deficiency was identified. One of 1 deficiencies was a repeat violation (see SOD YY0Q11, dated 10/07/2021). Census: 1	M 000		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency 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. This Rule is not met as evidenced by: Based on record review and interview, the Licensee did not complete 8 hours of continuing education training related to the health, safety, welfare, rights and treatment of residents for the years of 2022 and 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) YY0Q11, dated 10/07/2021. Findings include: The provider is licensed to care for 4 residents in the client groups developmentally disabled, emotionally disturbed/mentally ill and alcohol/drug dependent.	M 246		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010451	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR FAMILY HOME	**425 ABRAMS ST GREEN BAY, WI 54302**

(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 246	Continued From page 1 On 10/22/2024, during the entrance interview, Licensee A told Surveyor s/he was the only employee at this time. On 10/22/2024, Surveyor requested and reviewed Licensee A's employee record for evidence of continuing education. Licensee A's date of hire was 04/27/2004. Licensee A's record did not contain evidence of receiving 8 hours of training in 2022 or 2023. Licensee A's record included documentation of 1 hour of continuing education completed on 04/20/2023. On 10/22/2024 at 12:30 PM, Surveyor interviewed Licensee A regarding the 8 hours of training. Licensee A confirmed s/he had no additional training for 2022 and only completed one-hour of training for 2023. Aside from that, Licensee A had no additional training for 2023. Licensee A verified s/he did not complete 8 hours of training in 2022 and 2023.	M 246		