STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018839	A. BUILDING: _____ B. WING _____	R-C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW WAY OF LIVING ADULT FAMILY HOME #2	4114 ST CLAIR STREET RACINE, WI 53402

(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 12/05/2024, Surveyors completed a verification visit and complaint investigation at New Way of Living Adult Family Home #2. As a result, the previous deficiency was corrected, and a new deficiency was identified. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 3	{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 report to the licensing agency, within 24 hours, a significant change in 1 of 1 resident's status. Resident 5 attempted suicide and was hospitalized. Finding include: On 12/04/2024, at 7:40 AM, Surveyors reviewed the Department's facility file. Surveyors did not	M 134		

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
	0018839	A. BUILDING: _____ B. WING _____	R-C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW WAY OF LIVING ADULT FAMILY HOME #2	**4114 ST CLAIR STREET RACINE, WI 53402**

(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 134	Continued From page 1 observe any self-reports submitted to the Department in November 2024. On 12/05/2024, at 9:18 AM, Surveyors interviewed Licensee A. Licensee A reported s/he was unaware of the code requirement. Licensee A reported s/he did not know Resident 5 was attempting suicide until after s/he was at the hospital. Licensee A reported Resident 5 was sent to the hospital due to being found on the floor in the basement. Licensee A confirmed the attempted suicide was a significant change. Licensee A reported s/he would ensure all self-reports are submitted as required.	M 134		