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
	0016535	A. BUILDING: _____ B. WING _____	R-C 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CARE FAMILY SERVICES LLC MEQUON I	9945 W WAUWATOSA ROAD MEQUON, WI 53092

(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 10/15/2025, Surveyor conducted a verification visit at New Care Family Services LLC Mequon II. As a result of the survey 4 of 5 deficiencies were corrected and 1 of 5 was a repeat violation for the third time. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
{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 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 have a written order from the physician who prescribed the medications, 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 for 1 of 4 residents reviewed, (Resident 5). This requirement is being cited for third time.	{M 464}		

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
	0016535	A. BUILDING: _____ B. WING _____	R-C 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CARE FAMILY SERVICES LLC MEQUON I	9945 W WAUWATOSA ROAD MEQUON, WI 53092

(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 464}	Continued From page 1 See Statement of Deficiency (SOD) W11311, dated 08/24/2020 and 0NNC13, dated 07/09/2025. Findings include: On 10/15/2025 at approximately 10:00 AM, Surveyor requested resident records from Caregiver C. Resident 5 admitted to the home on 08/26/2025. Resident 5's record did not include a physician order for the provider's staff to administer medications. Resident 5's individual service plan (ISP) reflected Resident 5 requires staff to administer medications, and their were medication administration records (MARS) for Resident 5 from date of admission signed by caregivers. On 10/15/2025 at 10:30 AM, Surveyor interviewed Administrator (ADM) B. ADM B stated Resident 5 had not seen the doctor yet, but s/he had him/her scheduled next month for an appointment. ADM B confirmed they were administering medications to Resident 5. As of 10/16/2025 at 9:00 AM, no additional documentation was received. The provider did not have a physician order to administer medication to Resident 5.	{M 464}		