

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012454	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/20/2023
NAME OF PROVIDER OR SUPPLIER GERMANTOWN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE W164N10502 TIMBERLINE CT GERMANTOWN, WI 53022		
(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
N 000	Initial Comments On 06/20/2023, Surveyor conducted an abbreviated survey at Germantown Home, a Community-Based Residential Facility (CBRF) in Germantown, WI. Two deficiencies identified. Census: 7	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012454	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/20/2023
NAME OF PROVIDER OR SUPPLIER GERMANTOWN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE W164N10502 TIMBERLINE CT GERMANTOWN, WI 53022		
(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
N 239	Continued From page 1 This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure Caregiver B received Department approved training courses within 90 days after starting employment and/or assuming job duties. Caregiver B did not have training in first aid and choking within 90 days after starting employment. Findings include: On 06/20/2023, Surveyor reviewed Caregiver B's employee record. Caregiver B was hired on 04/01/2011. The record for Caregiver B, hired 04/01/2011, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 06/20/2023, at approximately 11:45 AM, Surveyor interviewed Company Manager A. Company Manager A confirmed the provider did not have evidence Caregiver B completed or met an exemption for first aid and choking training. On 06/20/2023, Surveyor verified Caregiver B was not on the Community-Based Care and Treatment training registry for first aid and choking.	N 239		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a	Z 012		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012454	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/20/2023
NAME OF PROVIDER OR SUPPLIER GERMANTOWN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE W164N10502 TIMBERLINE CT GERMANTOWN, WI 53022		
(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
Z 012	Continued From page 2 resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have evidence of making a good faith effort to obtain out of state background check information for 1 of 1 applicable staff member. Caregiver B indicated on the Background Information Disclosure (BID) form that s/he had resided in the states of Indiana and California within the previous 3 years. Findings include: On 06/20/2023, Surveyor conducted an abbreviated survey. As part of the survey process, Surveyor reviewed employee records.	Z 012		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012454	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/20/2023
NAME OF PROVIDER OR SUPPLIER GERMANTOWN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE W164N10502 TIMBERLINE CT GERMANTOWN, WI 53022		
(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
Z 012	Continued From page 3 Caregiver B's employee record indicated a date of hire on 05/02/2023. Caregiver B completed the BID form on 05/02/2023 and checked "yes" to having resided in another state (Indiana & California) in the previous 3 years. The employee record did not contain evidence the facility had made a good faith effort to obtain state of Indiana and California background checks. On 06/20/2023 at approximately 12:00 PM, the above information was shared with Company Manager A. Company Manager A acknowledged not completing an out of state background check on Caregiver B. Company Manager A stated s/he wasn't aware of the requirements for out of state background checks. Company Manager A stated the provider would conduct the required out of state background checks moving forward if applicable and complete Caregiver B's out of state background check as soon as possible.	Z 012		