STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 07/11/2023, Surveyor conducted a standard survey at Caring Homes LLC, an Adult Family Home (AFH) in Mequon, WI. 11 deficiencies identified. Census: 4	M 000		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not have Caregiver B complete 15 hours of training related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. On 07/11/2023, Surveyor conducted a standard survey. As part of the survey process, Surveyor requested to review Caregiver B's initial training. Caregiver B was hired on 10/15/2021. Surveyor reviewed Caregiver B's initial orientation training. The training did not list the amount of hours	M 244		

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
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 244	Continued From page 1 Caregiver B completed. At approximately 10:30 AM on 07/11/2023, Surveyor asked Manager A if s/he had a copy of the orientation training in detail with the amount of hours covered. Manager A stated they do not and it would not show how many hours of training Caregiver B had. Manager A was unable to verify if Caregiver B received 15 hours of training prior to or within the first 6 months of employment as required.	M 244		
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 have Caregiver B complete 8 hours of training including resident rights for calendar year 2022. On 07/11/2023, Surveyor conducted a standard survey. As part of the survey process, Surveyor requested to review Caregiver B's 2022 calendar year training. Caregiver B was hired on 10/15/2021. The training did not list the amount of hours Caregiver B completed for calendar year 2022 and did not	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 246	Continued From page 2 include resident right training. At approximately 10:30 AM, Surveyor asked Manager A if s/he had a copy of the continuing education training in detail with the amount of hours covered. Manager A stated they do not have record of this and was unable to verify Caregiver B received any continuing education training in 2022.	M 246		
M 282	88.05(3)(d) ANNUAL WELL WATER INSPECTIONS Where a public water supply is not available water samples shall be taken from the well and tested at the state laboratory of hygiene or other laboratory approved under ch. HSS 165 at least annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure water samples were taken from the well and tested at the state laboratory of hygiene or other approved laboratory at least annually. Findings include: On 07/11/2023, Surveyor conducted a standard survey. As part of the survey process, Surveyor requested to review well water tests from calendar year 2022. At approximately 11:00 AM on 07/11/2023, Manager A could only locate a well water test from calendar year 2018. Manager A stated s/he would let Licensee know that it needs to be completed annually.	M 282		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 332	Continued From page 3 Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 3 of 3 fire extinguishers were inspected annually by the authorized dealer or fire department. Three extinguishers were last inspected in May 2022. Findings include: The facility is licensed as an adult family home, able to serve up to 4 residents within the client groups of: Advanced Age, Irreversible Dementia/Alzheimer's, Emotionally Disturbed/Mentally Ill, Developmentally Disabled, Alcohol/Drug Dependent, Correctional Clients, Physically Disabled, Terminally Ill and Traumatic	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 332	Continued From page 4 Brain Injury. On 07/11/2023, Surveyor conducted a standard survey. During a tour of the facility, 3 fire extinguishers were observed, mounted, with tags indicating the last inspection was completed in May 2022. On 07/11/2023 at approximatelt 9:40AM, Surveyor interviewed Manager A and asked if s/he was aware fire extinguishers were required to be inspected annually. Manager A checked the tag on the fire extinguishers. Manager A acknowledged it was overdue and was aware fire extinguishers in the facility needed to be inspected annually.	M 332		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not review the fire safety evacuation plan with Resident 1 immediately following his/her placement. Findings include:	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 344	Continued From page 5 On 07/11/2023, Surveyor conducted a standard survey. Surveyor requested to review Resident 1's evacuation assessment upon admission. Resident 1 was admitted to the facility on 06/27/2022. Resident 1 had the evacuation assessment form in his/her record but it was not filled out and completed. On 07/11/2023 at approximately 11:45 AM, Surveyor reviewed the above information with Manager A. Manager A stated it did not get done and s/he would let the licensee know so that it can be completed.	M 344		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not evaluate Resident 2 annually for his/her evacuation time. Findings include: On 07/11/2023, Surveyor conducted a standard survey. Surveyor requested to review Resident 2's evacuation assessment for calendar year 2022. Resident 2 was admitted to the facility on 04/17/2021. Resident 2 only had a copy of an	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 346	Continued From page 6 evacuation assessment from his/her admission on 04/17/2021. On 07/11/2023 at approximately 11:50 AM, Surveyor reviewed the above information with Manager A. Manager A stated it did not get done and s/he would let the licensee know so that it can be completed.	M 346		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents reviewed received a health exam, including a screening for communicable disease, within 90 days prior to admission or within 7 days after admission. Findings include: On 07/11/2023 at approximately 11:30 AM, Surveyor requested Resident 1 and Resident 2's record, including his/her communicable disease screen.	M 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 380	Continued From page 7 Resident 1 was admitted to the facility on 06/27/2022. Resident 1's record did not include a communicable disease screen. Resident 2 was admitted to the facility on 04/17/2021. Resident 2's record did not include a communicable disease screen. On 07/11/2023 at approximately 12:00 PM, Surveyor reviewed above information with Manager A. Manager A stated s/he wasn't sure where it would be and would reach out to Resident 1 and Resident 2's physician's and let the licensee know that this needs to be completed.	M 380		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a service agreement was completed for 1 of 1 resident reviewed. Resident 1 did not have a service agreement completed.	M 384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 384	Continued From page 8 Findings include: On 07/11/2023 at approximately 11:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/27/2022. Surveyor could not locate an admission agreement. On 07/11/2023 at approximately 12:00 PM, Surveyor reviewed the above information with Manager A. Manager A stated s/he could not locate an admission agreement for Resident 1. Manager A stated that s/he would let the licensee know it needed to be completed.	M 384		
M 456	88.07(2)(e) ANNUAL HEALTH EXAM The licensee shall ensure that each resident has an annual health exam by a physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed had completed an annual health exam by a physician. Resident 2's record did not include an annual health exam. Findings include: On 07/11/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 04/17/2021. Surveyor observed no evidence showing Resident 2 completed an annual health	M 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 456	Continued From page 9 exam or had one scheduled in calendar year 2022. On 07/11/2023 at approximately 12:05 PM, Surveyor reviewed the above information with Manager A. Manager A stated s/he was unsure if Resident 2 had completed an annual health exam. Manager A stated s/he would have to send the information over to the licensee and see if Resident 2's physician had anything on file. Surveyor did not receive documentation of an annual health exam by a physician for Resident 2.	M 456		
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 obtain a written order from the physician who prescribed the medications, specifying who by name or position was permitted to administer the medication for 2 of 2 residents reviewed. Resident 1's and Resident 2's record did not contain a written order to administer medication.	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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 10 Findings include: On 07/11/2023, Surveyor reviewed resident record and identified the following: Resident 1 was admitted to the facility 06/27/2022. Resident 1's record did not contain a written order from the physician authorizing facility staff to administer medications. Resident 2 was admitted to the facility 04/17/2021. Resident 2's record did not contain a written order from the physician authorizing facility staff to administer medications. On 07/11/2023 at approximately 12:30 PM, Surveyor interviewed Manager A regarding the above concerns. Manager A confirmed staff had been responsible for administering Resident 1 and Resident 2's medications upon arrival to the facility. Manager A stated s/he was aware of the requirement, but could not locate a written order from Resident 1's and Resident 2's physician upon admission. Manager A stated the licensee was requesting Manager A to send both forms over to Resident 1's and Resident 2's physician to get them to sign off on the forms so that they would have a written order to administer medications as of 07/11/2023 for both residents.	M 464		
Z 005	50.065(2)(b)intro ENTITY BACKGROUND CHECK REQUIREMENTS 1. A criminal history search from the records maintained by the department of justice. 2. Every entity shall obtain all of the following with respect to a caregiver of the entity:	Z 005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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
Z 005	Continued From page 11 Information that is contained in the registry under s. 146.40(4g) regarding any findings against the person. 3. Information maintained by the department of safety and professional services regarding the status of the person's credentials, if applicable. 4. Information maintained by the department regarding any final determination under s. 48.981(3)(c)5m. or, if a contested case hearing is held on such a determination, any final decision under s. 48.981(3)(c)5p. that the person has abused or neglected a child. 5. Information maintained by the department under this section regarding any denial to the person of a license, certification, certificate of approval or registration or of a continuation of a license, certification, certificate of approval or registration to operate an entity for a reason specified in sub. (4m)(a)1. to 5. and regarding any denial to the person of employment at, a contract with or permission to reside at an entity for a reason specified in sub. (4m)(b)1. to 5. If the information obtained under this subdivision indicates that the person has been denied a license, certification, certificate of approval or registration, continuation of a license, certification, certificate of approval or registration, a contract, employment or permission to reside as described in this subdivision, the entity need not obtain the information specified in subds. 1. to 4.	Z 005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017815	A. BUILDING: _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HOMES LLC	919 W SIERRA LN 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
Z 005	Continued From page 12	Z 005		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a full background check was completed on 2 out of 2 staff record reviews.

Findings include:

On 07/11/2023, Surveyor conducted a standard survey. As part of the survey process, Surveyor requested to review Caregiver B and Caregiver C's background checks.

Caregiver B had an employment start date of 10/15/2021. Caregiver B's record did not include a Department of Justice Background check (DOJ) or an Integrated Background Information System check (IBIS) or an acceptable alternative.

Caregiver C had an employment start date of 06/18/2023. Caregiver C's record did not include a DOJ, an IBIS or an acceptable alternative.

On 07/11/2023 at approximately 12:30 PM, Surveyor interviewed Manager A who stated s/he was unable to find documentation that Caregivers B's or C's background check was completed.