STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017669	A. BUILDING: _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KETTLE PARK SENIOR LIVING INC	2600 JACKSON ST STOUGHTON, WI 53589

(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 06/04/2024, Surveyor conducted a complaint investigation at Kettle Park Senior Living Inc. One deficiency was identified. Complaint was substantiated. Census: 11	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider employed 1 of 1 (Former Caregiver B) caregivers reviewed who had a governmental finding of misconduct and had not been approved under the department's rehabilitation process. This had the potential to affect all 20 residents. Findings Include: On 04/10/2024, the Department received a	N 219		

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
	0017669	A. BUILDING: _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KETTLE PARK SENIOR LIVING INC	2600 JACKSON ST STOUGHTON, WI 53589

(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 219	Continued From page 1	N 219		

complaint that a caregiver working at the facility was listed on the caregiver misconduct registry.

On 06/04/2024, Surveyor conducted an onsite visit to the facility. Surveyor requested Caregiver B's record.

Caregiver B was hired on 01/08/2024. An Integrated Background Information Systems (IBIS) check completed on 12/27/2023 indicated Caregiver B had a misappropriation finding on 01/22/2008. The IBIS documented: "A Rehabilitation Review was completed for [Caregiver B] on 01/11/2022. You must verify eligibility by contacting the DHS Office of Legal Counsel."

On 06/04/2024, at approximately 12:30 PM, Surveyor interviewed Director of Health Services A. Surveyor reviewed the IBIS, the Misconduct Registry, and the Nurse Aide Program registry with the Director of Health Services A. Director of Health Services A stated, "We missed the language on the IBIS. Going forward, we will have to look at that language closer."

On 06/04/2024 at 12:44 PM, Surveyor emailed the Wisconsin Nurse Aide Training and Registry Team to verify that Caregiver B was not approved to work in a CBRF (community-based residential facility) and/or a RCAC (residential care apartment complex). Surveyor was informed: "This aide does have a rehab review that lists certain settings [s/he] can work in but this facility type of setting was not an approved setting. ... [S/he] did meet the requirements for renewal of certification (worked as a nurse aide under the supervision of a nurse) so worked with OCQ (office of caregiver quality) to determine we could renew [his/her] certification- however we also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017669	A. BUILDING: _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KETTLE PARK SENIOR LIVING INC	2600 JACKSON ST STOUGHTON, WI 53589

(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 219	Continued From page 2 notified the rehab review coordinator that [s/he] was working in a facility not approved under [his/her] review. The aide would need to request another rehab review application to seek approval for CBRF or RCAC."	N 219		