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
	0014954	A. BUILDING: _____ B. WING _____	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MEADOWS FAMILY CARE ANGEL H	13207 HWY G CALEDONIA, WI 53108

(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 08/05/2025, Surveyor conducted a standard survey at Country Meadows Family Care Angel House. One deficiency was identified. Census: 04	M 000		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure smoke detectors were maintained in working condition. Two of 7 required smoke detectors were not in working order. Findings include: On 08/05/2025, at approximately 12:00 PM, Surveyor completed tour of the facility. The facility is a ranch style home with 4 bedrooms, living room, kitchen, and full basement. During the tour of the facility, the smoke detector in the family room was observed to have a smoke detector mount but no smoke detector. The smoke detector in the northwest bedroom was tested and found to be not working due to a bad battery.	M 336		

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
	0014954	A. BUILDING: _____ B. WING _____	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MEADOWS FAMILY CARE ANGEL H	13207 HWY G CALEDONIA, WI 53108

(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 336	Continued From page 1 On 08/05/2025, at approximately 12:30 PM, Surveyor interviewed Administrator A and asked if they conducted monthly testing of all smoke detectors. Administrator A showed Surveyor completed logs which documented all smoke detectors were tested and found working on 07/2025. Administrator A was unsure why the smoke detector was missing in the family room but stated they would have both smoke detectors operational by the end of the day.	M 336		