STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390147	A. BUILDING: _____ B. WING _____	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN VALLEY	1128 GREEN VALLEY DR WAUKESHA, WI 53189

(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 From 11/11/2025 to 11/18/2025, Surveyor conducted a standard survey at Green Valley an Adult Family Home (AFH) in Waukesha, WI. One deficiency was identified. Census: 4	M 000		
Z 019	50.065(6)(am) Four Year Caregiver Background Requirement Every 4 years an entity shall require its caregivers and nonclient residents to complete a background information form that is provided to the entity by the Department. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete background check was completed every 4 years for 2 of 3 caregivers reviewed. The provider did not complete a timely 4-year background check for Caregiver A and Caregiver B. Findings include: On 11/11/2025 at approximately 11:00 a.m., Surveyor requested 3 staff records from Supervisor C. Supervisor C stated that Licensee D would email all staff records over by 11/12/2025. Surveyor received all staff files on	Z 019		

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
	390147	A. BUILDING: _____ B. WING _____	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN VALLEY	1128 GREEN VALLEY DR WAUKESHA, WI 53189

(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 019	Continued From page 1 11/11/2025 at 10:41 p.m. On 11/13/2025 at approximately 11:00 a.m., Surveyor reviewed Caregiver A and Caregiver B 's record. The record documented the following: -Caregiver A was hired on 10/26/2017 and his/her background checks were completed on 12/02/2020 and 10/02/2025. The provider did not complete a timely 4-year background check for Caregiver A. - Caregiver B was hired on 07/20/2020 and his/her most recent background check was completed on 09/26/2025, greater than 4 years from the previous background check. On 11/18/2025 at approximately 12:00 p.m., Surveyor shared concern with Licensee D that Caregiver A and Caregiver B's background check had not been completed every 4 years. Licensee D acknowledged that the background checks were not completed every 4 years. Licensee D stated that s/he "had miscalculated the dates on those employees."	Z 019		