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
	0017992	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW WAY OF LIVING ADULT FAMILY HOME	**221 CHICAGO STREET RACINE, WI 53405**

(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 04/15/2025, Surveyor completed a standard survey and complaint investigation at New Way Of Living Adult Family Home. As a result, 1 deficiency was identified. The complaint was unsubstantiated. Census : 4	M 000		
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 provider did not ensure each service provider received annual training for 3 of 3 caregivers. Caregiver B, Caregiver C, and Caregiver D did not receive annual training in 2023 and 2024. Findings include: On 04/15/2025, at 10:00 AM, Surveyor reviewed employee records and identified the following: Caregiver B was hired on 07/27/2023. Caregiver B's record did not contain any evidence of annual training in 2024.	M 246		

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
	0017992	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW WAY OF LIVING ADULT FAMILY HOME	**221 CHICAGO STREET RACINE, WI 53405**

(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 1 Caregiver C was hired on 06/09/2021. Caregiver C's record did not contain any evidence of annual training in 2023 and 2024. Caregiver D was hired on 03/30/2020. Caregiver D's record did not contain any evidence of annual training in 2023 and 2024. On 04/15/2025, at 11:30 AM, Surveyor interviewed Licensee A. Licensee A confirmed staff were required to have 8 hours of annual training. Licensee A reported s/he was looking for another resource to conduct the annual trainings.	M 246		