

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ABILITIES MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 1218 STATE ST RIVER FALLS, WI 54022		
(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 01/14/2025, Surveyor conducted a complaint investigation and verification visit at Abilities Midwest. Data collection continued through 01/15/2025. The complaint was unsubstantiated. Four of 7 deficiencies identified in Statement of Deficiency (SOD) KW4Y11, dated 01/10/2024 were corrected. Three deficiencies were identified and were repeat deficiencies (see SOD KW4Y11, dated 01/10/2024). Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}		
{M 114}	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the	{M 114}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ABILITIES MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 1218 STATE ST RIVER FALLS, WI 54022		
(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 114}	Continued From page 1 licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees sampled had a complete caregiver background check upon hire. This is a repeat deficiency. See Statement of Deficiency (SOD) KW4Y11, dated 01/10/2024. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete background check consists of: 1) A completed DHS (Department of Health Services) form F-82064, Background Information Disclosure (BID).	{M 114}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ABILITIES MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 1218 STATE ST RIVER FALLS, WI 54022		
(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 114}	Continued From page 2 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check (CBC)" letter from the DHS. On 01/14/2025 at approximately 3:50 PM, Surveyor received an email from Operations and Transportation Coordinator (OTC) A with Caregiver C's background check information. Caregiver C had a hire date of 06/10/2024. The DOJ and CBC response letter was dated 01/14/2025 (the date of survey). OTC A stated via email, "Here is what I have for [Caregiver C]. You will see that [his/her] Background [sic] study is dated for today. The reason for this is because [his/hers] is, of course, the only one that was not in the original file that I was given, so I made the call to run it again [sic] so I didn't miss your deadline." As of 01/15/2024, no additional documentation was received to show Caregiver C had a complete CBC completed prior to the date of survey.	{M 114}		
{M 232}	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation	{M 232}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ABILITIES MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 1218 STATE ST RIVER FALLS, WI 54022		
(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 232}	Continued From page 3 shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees were screened by a physician, a registered nurse, or a physician's assistant for illness detrimental to residents, within 90 days before the start of providing service. This is a repeat deficiency. See Statement of Deficiency (SOD) KW4Y11, dated 01/10/2024. Findings include: On 01/14/2025, Surveyor requested to review health screenings for Caregiver B, Caregiver C and Caregiver D. Caregiver B had a hire date of 04/15/2024. Caregiver C had a hire date of 06/10/2024. Caregiver D had a hire date of 10/22/2024. Caregiver B, Caregiver C, and Caregiver D had tuberculosis (TB) test results on file but did not have documentation on file indicating they were screened by a physician, registered nurse, or a physician's assistant for illness detrimental to residents. On 01/14/2025 at approximately 3:35 PM, Surveyor received an email from Operations and Transportation Coordinator (OTC) A that read, in part: "...I wasn't sure what the Communicable	{M 232}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ABILITIES MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 1218 STATE ST RIVER FALLS, WI 54022		
(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 232}	Continued From page 4 Disease Screening was, so I called the clinic where we have our TB tests run and [s/he] walked me through it. So, as I promised, in full honesty, we haven't run the tests that way before, but I have it now clear with the clinic that we will be having that full screening done instead of just the TB test for any new hires."	{M 232}		
{Z 012}	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions.	{Z 012}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ABILITIES MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 1218 STATE ST RIVER FALLS, WI 54022		
(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 012}	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a good faith effort was made to obtain an out of state background check, for 3 of 3 employees reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) KW4Y11, dated 01/10/2024. Findings include: On 01/14/2025, Surveyor requested to review background checks for Caregiver B, Caregiver C and Caregiver D from Operations and Transportation Coordinator (OTC) A. On 01/14/2025 at approximately 3:40 PM, Surveyor received an email from OTC A with Caregiver B's background check information. Caregiver B had a hire date of 04/15/2024, and indicated s/he resided in Minnesota his/her "entire life" on the Background Information Disclosure (BID) form, dated 04/14/2024. OTC A stated via email, "Here is the information I have for [Caregiver B]. In speaking with [Licensee A] about the out of state background checks for both this [Caregiver B] and the other [sic]. [s/he] explained to me that [s/he] has been working with MN (Minnesota) on how to navigate that, and they stated that [facility name] must be a listed provider for them to do the background check. We are still, 8 months or so later, trying to get added as a provider to their list..." On 01/14/2025 at approximately 3:50 PM, Surveyor received an email from OTC A with Caregiver C's background check information.	{Z 012}		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ABILITIES MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 1218 STATE ST RIVER FALLS, WI 54022		
(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 012}	Continued From page 6 Caregiver C had a hire date of 06/10/2024. Caregiver C indicated s/he resided in Minnesota from 2017-2024 on the BID form, dated 06/11/2024. The DOJ and caregiver response letter was dated 01/14/2025 (the date of survey). OTC A stated via email, "Here is what I have for [Caregiver C]. You will see that [his/her] Background [sic] study is dated for today. The reason for this is because [his/hers] is, of course, the only one that was not in the original file that I was given, so I made the call to run it again so I didn't miss your deadline. I hope that was an ok thing to do. As I said in the last email, [s/he] too is from MN so we have the same issue with [his/her] out of state check. Please let me know if there is anything else I can do for you. Also, we are quite far down the road to being listed as a licensed provider for MN, and the hope is that we accomplish that feat within then next month." Caregiver D had a hire date of 10/22/2024. Caregiver D indicated s/he resided in Minnesota from 2015-2024 on the BID form, dated 10/23/2024. Documentation of a Minnesota background check was not available for Caregiver D.	{Z 012}		