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
	0018454	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE RESIDENTIAL 2	1601 W 6TH ST RACINE, WI 53403

(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 11/05/2025, Surveyor conducted a desk review for Best Care Residential 2. One deficiency was identified.	M 000		
M 122	88.03(4)(b) RENEWAL REQUIREMENTS To renew a license, the licensee shall submit to the licensing agency not less than 30 days prior to the date of expiration of the current license, a completed application form, a new program statement if there have been any program changes, the licensure fee required under s. 50.033(2), Stats., and any required fee for a criminal records check. If the license is not renewed, the licensing agency shall give the licensee written notice before expiration of the license. The notice shall clearly and concisely state the reasons for not renewing the license and shall inform the licensee of the opportunity for a hearing under sub. (7). This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the biennial report and license fee were submitted to the department within 30 days prior to the license expiration date. Findings include: On 03/25/2025, the department sent a notice to Licensee A informing them the license for Best Care Residential 2, would expire on 05/31/2025.	M 122		

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
	0018454	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE RESIDENTIAL 2	1601 W 6TH ST RACINE, WI 53403

(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 122	Continued From page 1 The notice indicated the biennial report and license fee were due to the department by 05/01/2025. On 05/07/2025, the department sent a second notice to Licensee A by email, indicating the biennial report and license fee were past due. The notice indicated if the biennial report and license fee were not received by 06/30/2025, the Division of Quality Assurance will proceed with enforcement action, which may include license revocation. On 05/07/2025, the department received a confirmation of delivery. On 05/07/2025, the department sent a second notice to Licensee A by certified letter, indicating the biennial report and license fee were past due. The notice indicated if the biennial report and license fee were not received by 06/30/2025, the Division of Quality Assurance will proceed with enforcement action, which may include license revocation. On 05/28/2025, United States Postal Service (USPS) returned the notice as undeliverable. On 06/09/2025, the department sent a second notice to Licensee A by certified letter, indicating the biennial report and license fee were past due. The notice indicated if the biennial report and license fee were not received by 06/30/2025, the Division of Quality Assurance will proceed with enforcement action, which may include license revocation. On 06/14/2025, the department received a confirmation of delivery.	M 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018454	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE RESIDENTIAL 2	1601 W 6TH ST RACINE, WI 53403

(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 122	Continued From page 2 On 07/23/2025, at 8:50 AM, Surveyor called the facility phone number and a staff member of the facility answered. The staff member reported they would give the message to Licensee A to return the call to the department. No return call was received. On 11/05/2025, Surveyor reviewed department records and found no evidence a biennial report and license fees were received from the provider. The license expired on 05/31/2025.	M 122		