

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0014807</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/27/2025</b> |
|-----------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**CATCHUCARE SERVICES**

**4430 W ROOSEVELT DRIVE  
MILWAUKEE, WI 53216**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| M 000                    | INITIAL COMMENTS<br><br>On 08/27/2025, Surveyor attempted to complete a standard survey at Catchucare Services. As a result, 1 deficiency was identified.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | M 000               |                                                                                                                          |                          |
| M 204                    | 88.03(8)(a) MONITORING OF HOME<br><br>The licensee shall comply with all department and licensing agency request for information about residents, services or operation of the home.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not comply with all department and licensing agency requests for information about residents, services or operation of the home.<br><br>Findings include:<br><br>On 08/22/2025, at 12:30 PM, Surveyor attempted to conduct a standard survey at the facility. Surveyor rang the doorbell and then knocked at the door. Surveyor did not observe any lights on within the home or cars in the driveway.<br><br>At 12:46 PM, Surveyor called the facility phone number. The message indicated the line had been disconnected. Surveyor then called Licensee A's phone number. Surveyor left a voicemail for Licensee A to call Surveyor back as soon as possible.<br><br>Surveyor left the home at 1:10 PM.<br><br>On 08/26/2025, at 9:00 AM, Surveyor attempted a second visit to conduct a standard survey. | M 204               |                                                                                                                          |                          |

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0014807</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/27/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CATCHUCARE SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4430 W ROOSEVELT DRIVE<br/>MILWAUKEE, WI 53216</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| M 204                                                          | <p>Continued From page 1</p> <p>Surveyor rang the doorbell and then knocked at the door. The home appeared dark. Surveyor did not observe any cars in the driveway.</p> <p>At 9:17 AM, Surveyor called the facility phone number. The message again indicated the line had been disconnected. Surveyor again called Licensee A's phone number and left a voicemail for Licensee A to call Surveyor back immediately.</p> <p>At 9:22 AM, Surveyor sent Licensee A an email with a request of a call back as soon as s/he received the email. At 9:22 AM, Surveyor received a delivery receipt the email had been received by Licensee A's email.</p> <p>As of 08/27/2025, at 12:00 PM, Surveyor did not receive a response from Licensee A.</p> | M 204                                                                                          |                                                                                                                          |                                                        |