STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019259	A. BUILDING: _____ B. WING _____	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT LAKES HOME HEALTHCARE LLC	104 W 4TH ST KAUKAUNA, WI 54130

(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 07/07/2025 with additional information gathered through 07/09/2025, Surveyor conducted a standard survey at Great Lakes Home Healthcare LLC in Kaukauna. As a result of the survey, 6 deficiencies were identified. Census: 3	M 000		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain a safe, clean, and homelike environment. Findings include: The provider is licensed to care for up to 4 residents who may be developmentally disabled. On 07/07/2025 at approximately 3:35 PM during a tour accompanied by House Manager (HM) A, Surveyor observed the following: *The inside of the front door was white in color and was dirty with fingerprints that were black and gray in color.	M 276		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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M 276	Continued From page 1 *There was carpeting on the steps leading upstairs to resident bedrooms and the living room. The carpeting on the steps and in the living room had dark spots/stains throughout. *The blinds in the living room were dusty and broken. Resident 1's bedroom (upstairs and near the front of the house and staff bathroom): *The blinds were broken. *There was carpeting covering the entire floor. The carpeting had wrappers and crumbs on various areas of the floor. Resident 3's bedroom (upstairs and near the front of the house): *The blinds were broken. *There was carpeting covering the entire floor. The carpeting had wrappers, crumbs, dark spots/stains throughout the room. Resident bathroom: *The bathtub was dirty with soap scum. Kitchen: *The refrigerator and freezer had dried food/liquid splatter and residue on the shelves and on the bottom. *There was limited food. Residents did not have direct access to food. Residents needed to ask permission for food which was stored in the basement and affected 3 of 3 residents. On 07/07/2025 at approximately 4:10 PM, Surveyor observed 2 cans of green beans and a box of grits in the kitchen pantry and various condiments in the refrigerator and a few leftover food items. Surveyor inquired about the limited food in the kitchen from HM A. S/he stated food is	M 276		

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M 276	Continued From page 2	M 276		

mainly stored in the basement and only staff have access. HM A reported they cannot keep a lot of food in the pantry and refrigerator as Resident 3 will eat everything they put in there.

On 07/07/2025 at 4:20 PM, Surveyor observed as Resident 1 came downstairs to the staff office/bedroom and ask Caregiver C, "Can I get a bag of chips?" Resident 1 waited outside of the office door while Caregiver C grabbed him/her a bag of chips from the back/furnace room. Surveyor observed the door to the office/bedroom could be secured when staff were not present. Surveyor also observed the back/furnace room also had a door attached where the food was stored and could only be accessed through the office door.

On 07/07/2025 at approximately 4:25 PM, Surveyor interviewed HM A regarding a cleaning schedule and s/he stated, "Every Sunday is our super clean day." Surveyor discussed the various concerns in the home. HM A acknowledged Surveyors concerns and stated s/he would discuss with Licensee B.

On 07/09/2025 at 11:13 AM, Surveyor received a follow up email with attached pictures from Licensee B stating the blinds have been replaced in Resident 1 and Resident 3's bedrooms.

On 07/09/2025 at 1:00 PM, Surveyor interviewed Licensee B who acknowledged Surveyor's concerns. S/he stated, "Staff have a cleaning chart and should be cleaning on every shift. Parents and staff clean [Resident 3's] room. We attempt to clean it on a daily basis but [s/he] becomes combative." Licensee B also reported, "[Resident 3] eats a lot. [S/he] will eat the entire home if you let [him/her]. We keep the food

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M 276	Continued From page 3 stored downstairs and [residents] will come down and get snacks if they need to. We ask them what they want to eat." Licensee B stated s/he will try to come up with an alternative to ensure all residents have access to food and don't need to ask permission for food.	M 276		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not test each smoke detector monthly to ensure it was operational in 2023 and 2024. Findings include: The adult family home is licensed to care for 4 residents with developmental disabilities. On 07/07/2025 at approximately 2:15 PM, Surveyor reviewed facility records including monthly smoke detector testing for 2023 and 2024. Surveyor did not observe any smoke detector testing for 2023 or 2024. On 07/07/2025 at approximately 2:25 PM,	M 336		

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M 336	Continued From page 4 Surveyor interviewed Licensee B who stated s/he did not have any smoke detector documentation for 2023 or 2024 outside of the documented fire drills. Surveyor reviewed 3 documented fire drills in 2024 and did not observe any information on the form reflecting the smoke detectors were tested during those drills. Licensee B reported s/he was not aware the smoke detector testing needed to be documented. S/he stated s/he tests the smoke detectors every month even though they were not documented. Licensee B reported s/he will document them going forward. The provider did not test each smoke detector monthly in 2023 or 2024 to ensure they were operational.	M 336		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 (Resident 1 and Resident 3) residents reviewed were screened for	M 380		

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M 380	Continued From page 5 clinically apparent communicable disease including tuberculosis (TB), within 90 days before or 7 days after admission. Findings include: On 07/07/2025 at 2:30 PM, Surveyor reviewed Resident 1 and Resident 3's records, including their communicable disease screens. *Resident 1 admitted to the facility on 04/01/2023 and his/her record included a TB skin test from 04/11/2023, but did not contain a communicable disease screen. *Resident 3 admitted to the facility on 07/31/2024. Resident 3's record did not include evidence of an admission health exam and communicable disease screen, including a TB skin test. On 07/07/2025 at approximately 3:15 PM, Surveyor interviewed House Manager (HM) A regarding the above missing information. HM A stated s/he was not sure and would let Licensee B know. On 07/08/2025 at 11:48 AM, Surveyor sent a follow up email to Licensee B with the requested information including Resident 1's communicable disease screen and Resident 3's TB skin test and communicable disease screen. Surveyor requested the information by 3:00 PM on 07/08/2025. On 07/08/2025 at 3:09 PM, Surveyor received a follow up phone call from Licensee B. S/he confirmed Resident 1 does not have a communicable disease screen and Resident 3 does not have a TB skin test or communicable disease screen. Licensee B stated, "[Resident 3]	M 380		

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M 380	Continued From page 6 denies going to the doctor. [S/he] refuses and won't attend." On 07/08/2025 at 3:09 PM, Surveyor received a follow up phone call from Licensee B. S/he confirmed Resident 1 does not have a communicable disease screen and Resident 3 does not have a TB skin test or communicable disease screen. On 07/09/2025 at 1:00 PM, Surveyor interviewed Licensee B who confirmed Resident 1 and Resident 3 do not have communicable disease screens. Licensee B also stated Resident 3 does not have a TB skin test and admission health exam. S/he reported, "[Resident 3] refuses to go to the doctor. [S/he] has had scheduled appointments and [his/her] guardian will bring [him/her], but [Resident 3] says [s/he] doesn't want to go and brings [him/her] home. [S/he] gets combative when it comes to [his/her] health. I need some assistance."	M 380		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever	M 424		

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M 424	Continued From page 7	M 424		

the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 resident's (Resident 1 and Resident 3) Individual Service Plans (ISP) were reviewed at least every 6 months by the licensee, the resident or the resident's guardian.

Findings include:

On 07/07/2025 at 2:30 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the home on 04/01/2023, has a guardian and was placed by a managed care organization. Resident 1's record included a care plan from the managed care organization from 2023. There were no other ISPs located in Resident 1's record.

On 07/07/2025 at 3:05 PM, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the home on 07/31/2024, has a guardian and was placed by a managed care organization. Resident 3's record included a care plan (date unknown) from the managed care organization. There were no other ISPs located in Resident 3's record.

On 07/07/2025 at approximately 3:15 PM, Surveyor interviewed House Manager (HM) A regarding Resident 1 and Resident 3's ISPs. HM A stated s/he was not sure about any additional ISPs and would let Licensee B know.

On 07/08/2025 at 11:48 AM, Surveyor sent a

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M 424	Continued From page 8 follow up email to Licensee B with the requested information including Resident 1 and Resident 3's signed ISPs. Surveyor requested the information by 3:00 PM on 07/08/2025. On 07/08/2025 at 4:05 PM and 4:30 PM, Surveyor received emails from Licensee B with attachments. Surveyor reviewed the attachments and observed a document titled "Individualized Care Plan for [Resident 1]" with an "Acknowledge Date: 07-08-25." Surveyor observed signatures at the bottom of the document from Licensee B, Resident 1 and Resident 1's guardian, but no dates. Surveyor observed an additional document titled "Individualized Care Plan for [Resident 3]" with a "Date of Plan: 07-08-2025." Surveyor observed signatures at the bottom of the document from Licensee B, Resident 3 and Resident 3's guardian with a signature date of 07/08/2025. No additional ISP's were provided for Resident 1 or Resident 3. On 07/09/2025 at 1:00 PM, Surveyor interviewed Licensee B who stated s/he updates resident ISPs every 6 months on their electronic record. Licensee B stated, "I update their goals and tailor them towards their needs. I have never sent them out for review or signatures though. I didn't know I needed to, but will do that going forward." The provider did not ensure 2 of 2 ISPs reviewed were updated at least once every 6 months and included the resident or the resident's guardian.	M 424		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for	M 550		

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M 550	Continued From page 9	M 550		

personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 3 of 3 residents had privacy in their own home. There was 1 camera upstairs on the main level of the home used by all residents.

Findings Include:

The provider is licensed to care for up to 4 residents who may be developmentally disabled.

On 07/07/2025 at approximately 3:35 PM, during a tour of the home accompanied by House Manager (HM) A, Surveyor observed a camera in the living room of the home. The camera was sitting on a black shelf in the right-hand corner of the living room. Residents would be captured entering and exiting the living room and kitchen area. Surveyor observed Resident 1 laying on the couch and watching TV in the living room.

On 07/07/2025 at approximately 3:50 PM, Surveyor interviewed Resident 2 who stated, "The cameras work. Staff can talk to us through them."

On 07/07/2025 at approximately 4:25 PM,

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M 550	Continued From page 10 Surveyor inquired about the use of the camera in the living room with HM A. Surveyor explained camera use in these areas are an invasion of privacy. S/he stated s/he was not aware and would let Licensee B know. Surveyor asked if staff are able to communicate with residents through the camera and HM A stated s/he did not know. HM A reported Licensee B is the only one who has access to the camera in the living room. On 07/09/2025 at 1:00 PM, Surveyor interviewed Licensee B who confirmed the camera has been removed from the living room. S/he stated, "The camera is for our security system. It doesn't record 24-7. I only use it for emergencies. I can talk and see them through it, and I am the only one that has access to it." Licensee B reported s/he has talked to residents through it in the case of an emergency, but could not recall what the situation was. S/he stated if the alarm is set at night and if a resident opens the door, s/he will get notified on his/her phone. The provider did not ensure 3 of 3 residents had privacy in their own home.	M 550		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident	M 570		

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M 570	Continued From page 11 because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard residents who cannot fully guard themselves from environmental hazards. The provider did not ensure the dryer vent was made of rigid venting. Findings include: The provider is licensed to care for up to 4 residents who may be developmentally disabled. "House fires caused by dryers are more common than many people realize, based on statistics from the National Fire Protection Agency and the Consumer Product Safety Commission, which cite that around 15,000 fires each year can be attributed to improper lint cleanup and maintenance of the home's clothes dryer. Fortunately, these fires are very easy to prevent. The recommendations outlined below reflect International Residential Code (IRC) SECTION M1502 CLOTHES DRYER EXHAUST guidelines: M1502.5 Duct construction. Exhaust ducts shall be constructed of minimum 0.016-inch-thick (0.4 mm) rigid metal ducts, having smooth interior surfaces, with joints running in the direction of air flow. Exhaust ducts shall not be connected with sheet-metal screws or fastening means which extend into the duct. This means that the flexible, ribbed vents used in the past should no longer be used. They should be noted as a potential fire hazard if observed	M 570		

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M 570	Continued From page 12 during an inspection." (Retrieved on 07/08/2025 from the International Association of Certified Home Inspectors web page at https://www.nachi.org/dryer-vent-safety.htm)." On 07/07/2025 at approximately 3:35 PM, Surveyor toured the home accompanied by House Manager (HM) A. Surveyor observed the venting to the home's dryer was made of semi-rigid material and was kinked, creating a safety hazard. Surveyor discussed with HM A and s/he stated s/he would inform Licensee B of the rigid metal requirement. On 07/09/2025 at 1:00 PM, Surveyor interviewed Licensee B who acknowledged Surveyor's concern and reported the dryer vent will be fixed today.	M 570		