

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/29/2026
NAME OF PROVIDER OR SUPPLIER KREATIVE KARE AFH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4307 WRIGHT AVE 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 07/29/2026, Surveyor concluded a standard survey and a complaint investigation at Kreative Kare AFH LLC. Two deficiencies were identified. One complaint was substantiated. Census: 3	M 000			
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure a service provider was always present in the home, when there was a resident in need of continuous care for 1 of 3 residents. Resident 1 had been diagnosed with epilepsy. Resident 1 had seizures and was paralyzed on his/her left side due to stroke. According to Wis. Admin. Code § DHS 88.02(9), continuous care means the need for supervision, intervention, or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night. Findings include: On 07/09/2026, the Department received a	M 218			

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: 0020334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/29/2026
NAME OF PROVIDER OR SUPPLIER KREATIVE KARE AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 WRIGHT AVE 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 218	Continued From page 1 complaint alleging the residents who needed supervision and cares were left alone. On 07/29/2026, Surveyor reviewed resident records and identified the following: -Resident 1 was admitted on 07/14/2025 with a diagnosis of epilepsy, bipolar disorder, anxiety disorder, paranoid schizophrenia, and major depressive disorder. Resident 1 was his/her own person. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 1's signed his/her admission agreement, dated 07/14/2025, read, "Services provided: 24-hour supervision." - Resident 1's Individual Service Plan (ISP), dated 07/14/2025, identified, "Level of Supervision: "[Resident 1] requires routine supervision and supportive prompting from staff to ensure s/he maintains appropriate daily hygiene, personal care routines, and overall wellbeing. Staff will provide guidance, reminders, and encouragement as needed ...Safety Considerations: Because [Resident 1] is ambulatory, staff will ensure that the home environment remains safe, clean, and free of hazards. Routine supervision will be maintained to support safe independent functioning." On 07/07/2026, Resident 1 was admitted to the hospital with a primary diagnosis of hypoxia. Resident 1's other diagnoses included: epilepsy, hypertension, late effect of cerebral infarction (heart attack), bipolar disorder, paranoid schizophrenia, and major depressive disorder. On 07/29/2026 at 9:00 a.m., Surveyor interviewed	M 218		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/29/2026
NAME OF PROVIDER OR SUPPLIER KREATIVE KARE AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 WRIGHT AVE 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 218	Continued From page 2 Resident 1, who stated on 07/06/2026, s/he was talking to a family member on the phone. Resident 1 stated s/he did not feel well, due to breathing issues, and his/her family wanted Resident 1 to go to the hospital. Resident 1 stated his/her family called 911 and both the paramedics and the fire department showed up that night. Resident 1 declined medical transport. On 07/29/2026 at 9:50 a.m., Surveyor interviewed Caregiver C, who stated Resident 1 had seizures and was paralyzed on his/her left side due to stroke. Caregiver C confirmed Resident 1 could not be left alone, due to his/her diagnoses. Caregiver C stated, "We do not leave anyone alone. We cannot do that at this group home." On 07/29/2026 at 10:20 a.m., Surveyor interviewed Resident 2, who stated, "Sometimes the staff leaves and goes up to the store. Both [Caregiver B] and [Caregiver C] do it." Resident 2 explained the store was approximately 2 blocks away and approximately 10-15 minutes, if you walked. On 07/29/2026 at 10:45 a.m., Surveyor interviewed Licensee A, who confirmed staff were available, in the home 24 hours a day. On 07/29/2026 at 11:45 a.m., Surveyor interviewed Caregiver B, who stated that on 07/06/2026, s/he was on the corner of the street, talking on his/her phone, when paramedics and the fire department pulled up in front of the facility. The fire department approached the door. Caregiver B approached the facility from the corner of the street. Caregiver B confirmed that there was one property/home between the facility and the corner of the street, and s/he was off the facility property. Caregiver B called Licensee A	M 218		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/29/2026
NAME OF PROVIDER OR SUPPLIER KREATIVE KARE AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 WRIGHT AVE 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 218	Continued From page 3 into the room and explained what happened the night of 07/06/2026, when the paramedics arrived. Caregiver B explained to Licensee A that s/he was off the facility property and outside of the home, on the corner of the street, on his/her telephone. Licensee A stated that the residents in the facility required 24-hour assistance and being on the corner of the street was too far away to respond to an emergency. Licensee A stated, "You need to be present in the home, if the residents need you. What if [Resident 1] had a seizure?" Cross Reference: N0408 DHS 88.06(3)(c) Assessment Identify Needs & Abilities	M 218		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by: Based on record reviews and interviews, the provider did not assess 1 of 1 resident to identify the needs and abilities regarding level of supervision required in the home and community. Resident 1's initial assessment did not include his/her level of supervision required in the home	M 408		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/29/2026
NAME OF PROVIDER OR SUPPLIER KREATIVE KARE AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 WRIGHT AVE 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 408	Continued From page 4 and community. Findings include: On 07/29/2026, Surveyor reviewed resident records and identified the following: -Resident 1 was admitted on 07/14/2025 with a diagnosis of epilepsy, bipolar disorder, anxiety disorder, paranoid schizophrenia, and major depressive disorder. Resident 1 was his/her own person. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. -Resident 1's pre-admission assessment, dated 07/14/2025, did not identify Resident 1's level of supervision required in the home or in the community. On 07/29/2026 at 10:50 a.m., Surveyor reviewed Resident 1's level of supervision located in his/her initial assessment with Licensee A. Licensee A confirmed Resident 1's level of supervision was not clearly identified in his/her assessment. Cross Reference: N0218 DHS 88.04(2)(b) Awake Staff for Continuous Care	M 408		