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
	0019723	A. BUILDING: _____ B. WING _____	R 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONDING LOVE WAUKESHA	**2165 LAURA LANE WAUKESHA, WI 53186**

(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 06/29/2026, Surveyor conducted 1 verification visit at Bonding Love Waukesha. One deficiency was identified. The deficiency is a repeat violation. See Statement Of Deficiency (SOD) IM0M11, dated 2/10/26. Six of 7 violations from SOD IM0M11, dated 2/10/26 were substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
{M 466}	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medication administration was recorded accurately for 3 of 3 residents reviewed. This is repeat deficiency. See Statement Of	{M 466}		

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
	0019723	A. BUILDING: _____ B. WING _____	R 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONDING LOVE WAUKESHA	2165 LAURA LANE WAUKESHA, WI 53186

(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 466}	Continued From page 1 Deficiency (SOD) IM0M11, dated 2/10/26. Findings include: The adult family home is licensed to serve up to 4 residents within the client groups of developmentally disabled and emotionally disturbed/mental illness. Caregiver B did not record Resident 1's, Resident 2's and Resident 3's 06/29/2026 AM medication administration at time of administration. On 06/29/2026, Surveyor arrived at the home at 9:30 AM. On 06/29/2026, Surveyor reviewed Resident 1's, Resident 2's and Resident 3's electronic medication administration records (MAR) for 06/29/2026 AM shift. The MARs identified scheduled time for administration was 8:00 AM. None of Resident 1's, Resident 2's or Resident 3's AM medications had been documented as administered (Photos 1 and 2). On 06/29/2026 at 10:02 AM, Surveyor interviewed Caregiver B who stated on06/29/2026 s/he administered Resident 1's AM medications at 7:30 AM, and Resident 2's and Resident 3's AM medications at 8:30 AM. Caregiver B stated s/he usually waited until the end of his/her shift to document medication administration, especially when working a double AM and PM shift because it was easier to document all medications administered throughout the day at the same time. Caregiver B stated s/he had been documenting medication administration this way since s/he started. Caregiver B stated s/he was not trained to document medication administration at time of administration.	{M 466}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019723	A. BUILDING: _____ B. WING _____	R 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONDING LOVE WAUKESHA	**2165 LAURA LANE WAUKESHA, WI 53186**

(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 466}	Continued From page 2 On 06/30/2026 at 1:58 PM, Surveyor discussed concern of not documenting medication administration at time medications were administered with Manager A who stated Caregiver B was trained to document medication administration at time of administration and s/he would retrain Caregiver B.	{M 466}		