STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 01/24/2025, Surveyor conducted a standard survey at Aegis Quality Care, an AFH in Madison. Seven deficiencies were identified. Census: 3	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50,	M 114		

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
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 114	Continued From page 1 Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a criminal records check was completed for 2 of 2 caregivers reviewed. The provider did not have record of complete background checks for Manager B and Caregiver D. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), a complete Caregiver Background Check, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A Governmental Findings Report from DHS that reports the person's status, including administrative finding or licensing restrictions (IBIS). On 01/24/2025 at approximately 10:30 a.m., Surveyor reviewed employee records. Records indicated the following: - Manager B was hired on 03/15/2023. Manager B's BID was dated 03/15/2023. Manager B's DOJ and IBIS were dated 09/19/2024. Surveyor asked Manager B if the provider had a background check that was completed at the time of his/her	M 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 114	Continued From page 2 hire. Manager B was unable to provide DOJ or IBIS documentation completed within 60 days of hire. - Caregiver C was hired on 01/15/2025 and was observed caring for residents while Surveyor was present. The provider did not have record of any background checks completed for Caregiver C. On 01/24/2025 at approximately 11:00 a.m., Surveyor interviewed Manager B. Surveyor requested documentation of a DOJ and IBIS completed within 60 days of hire for him/her and documentation of a background check completed at the time of Caregiver C's hire. Manager B stated s/he would need to follow up with Licensee A. Manager B was given until the end of the day to provide follow up documentation. As of 01/27/2025 at 10:00 a.m., Surveyor had not received documentation of background checks.	M 114		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification.	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 232	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure s/he obtained documentation from a physician, registered nurse or physician's assistant indicating 2 of 2 caregivers reviewed had been screened for illness detrimental to residents, including tuberculosis. The provider did not have documentation of a communicable disease screen, including tuberculosis test, for Manager B or Caregiver C. Findings include: On 01/24/2025 at approximately 10:30 a.m., Surveyor reviewed employee records and identified the following concerns: - Manager B was hired on 03/15/2023. Manager B's record included a tuberculosis test, dated 07/14/2023, approximately 4 months after his/her starting to provide care at the home. - Caregiver C was hired on 01/15/2025 and was observed caring for residents while Surveyor was present. Caregiver C's record did not include documentation of a communicable disease screen, including tuberculosis test. On 01/24/2025 at approximately 11:00 a.m., Surveyor interviewed Manager B. Surveyor asked if s/he had a tuberculosis test completed at the time of his/her hire. Manager B stated s/he had a tuberculosis test administered, but didn't know s/he needed to return for the reading within a certain timeframe, so s/he had the test redone in July. Surveyor asked if the provider had documentation of a communicable disease screen, including tuberculosis test, on file for Caregiver C. Manager B replied, "Yes," and stated s/he would need to follow up with Licensee	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 232	Continued From page 4 A. Manager B was given until the end of the day to provide follow up documentation. As of 01/27/2025 at 10:00 a.m., Surveyor had not received documentation of a communicable disease screen, including tuberculosis test, for Caregiver C.	M 232		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers reviewed, that had been employed for greater than 1 year, had received 8 hours of continuing education in 2024. Findings include: On 01/24/2025 at approximately 10:30 a.m., Surveyor reviewed employee records and identified the following concerns: - Manager B was hired on 03/15/2023. Manager B's record did not include documentation of continuing education in 2024.	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 246	Continued From page 5 - Licensee A received a regular license for the home on 09/21/2022. Licensee A's record documented s/he had completed 10 hours of continuing education in 2023 but did not document completion of any continuing education in 2024. On 01/24/2025 at approximately 11:00 a.m., Surveyor asked Manager B if s/he and Licensee A had completed continuing education in 2024. Manager B stated s/he had not completed continuing education in 2024 and that s/he was unaware of the requirement. Manager B stated s/he would need to follow up with Licensee A regarding his/her 2024 continuing education. Manager B was given until the end of the day to provide follow up documentation. As of 01/27/2025 at 10:00 a.m., Surveyor had not received any follow up documentation regarding continuing education.	M 246		
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 ensure the home's smoke	M 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 336	Continued From page 6 detectors were tested monthly to ensure that they were operating. Findings include: On 01/24/2025 at approximately 10:45 a.m., Surveyor toured the provider's home and reviewed environmental records with Manager B, who was managing the home while Licensee A was out of the country. Surveyor asked Manager B if the provider tested the smoke detectors monthly and documented doing so. Manager B replied, "I believe so," and provided Surveyor with a binder of environmental records. Surveyor reviewed the record, which indicated all smoke detector checks were blank. On 01/24/2025 at approximately 11:00 a.m., Surveyor reviewed concern with Manager B that the provider did not have documentation of smoke detector checks. Manager B stated s/he would need to follow up with Licensee A. Manager B was given until the end of the day to provide follow up documentation. As of 01/27/2025 at 10:00 a.m., Surveyor had not received documentation of smoke detector checks.	M 336		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes.	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 346	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed, who had resided at the provider's home for greater than 1 year, was evaluated annually for evacuation time, using the department's form. Resident 1 had not been re-evaluated for evacuation, using the department's form, in greater than 2 years. Findings include: On 01/24/2025 at approximately 9:45 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 11/17/2022. Resident 1's record included an evacuation assessment, using the department's form, dated 11/18/2022. The record did not include an updated evacuation assessment. On 01/24/2025 at approximately 11:00 a.m., Surveyor reviewed concern with Manager B that Resident 1's evacuation assessment, using the department's form, had not been updated since 2022. Manager B stated s/he would need to follow up with Licensee A to see if s/he had an updated form. Manager B was given until the end of the day to provide follow up documentation. As of 01/27/2025 at 10:00 a.m., Surveyor had not received documentation of an updated evacuation assessment for Resident 1.	M 346		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 424	Continued From page 8 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 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 1 of 2 residents had an individual service plan (ISP) that was reviewed at least once every 6 months. Resident 1's ISP had not been updated and reviewed in greater than 2 years. Findings include: On 01/24/2025 at approximately 9:45 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 11/17/2022. Resident 1's record included an ISP, dated 11/18/2022. The ISP indicated Resident 1 used a wheeled walker for mobility. On 01/24/2025 at approximately 11:00 a.m., Surveyor interviewed Manager B. Surveyor asked if Resident 1 still used a wheeled walker for mobility. Manager B replied, "No," and stated	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 424	Continued From page 9 Resident 1 had not used a wheeled walker for a long time. Surveyor asked Manager B if Resident 1 had an updated ISP that had been reviewed within the past 6 months and that indicated Resident 1 no longer required the use of a walker. Manager B stated s/he would need to follow up with Licensee A. Manager B was given until the end of the day to provide follow up documentation. As of 01/27/2025 at 10:00 a.m., Surveyor had not received documentation of an updated ISP for Resident 1.	M 424		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was prepared and stored in a sanitary manner. Findings include: On 01/24/2025 at approximately 10:45 a.m., Surveyor toured the provider's home with Manager B. Surveyor observed the following concerns: Refrigerator: - Bread, not dated, was stored in a grocery bag with no sanitary separation between the bread and grocery bag.	M 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 474	Continued From page 10 - The refrigerator contained several containers of food that were not dated or labeled, including 3 pasta dishes, a bean dish, 2 sausage links and 4 dishes wrapped in aluminum foil. - The refrigerator contained potato salad with an expiration date of 12/25/2024, spinach with an expiration of 12/23/2024 and queso dip with an expiration date of 12/21/2024. - The vegetable drawer contained a large plastic bag full of cooked rice that had a hole, exposing the rice, and no date. - There was a plastic bag full of pizza with no date. - The vegetable drawer had a dark brown sauce covering ¼ of the drawer bottom. - The refrigerator contained an open package of turkey lunch meat that was not dated. Freezer: - A shelf had dark brown hardened liquid on it. Microwave: - The surface had food particles scattered throughout the bottom and sides. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) On 01/24/2025 at approximately 10:50 a.m., Surveyor reviewed food safety and storage concerns with Manager B. Manager B disposed of the expired items. Manager B stated a lot of the unlabeled food was from a resident's family member and that s/he frequently reminded	M 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019144	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS QUALITY CARE	6913 BUCKHORN DR MADISON, WI 53718

(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 474	Continued From page 11 "everyone" that food needed to be labeled.	M 474		