STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 000	Initial Comments On 03/03/3035, with information gathered through 03/18/2025, Surveyors conducted a standard survey at Raymond House. Fifteen (15) deficiencies were identified. Census: 16	N 000		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review, and interview, the administrator did not supervise the daily operation of the CBRF to ensure residents received proper care and treatment, that their health and safety were protected and promoted and that their rights were respected. Findings include: From 03/03/2025 to 03/18/2025, Surveyors conducted a standard survey, which resulted in the following concerns:	N 214		

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
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 214	Continued From page 1 Environment: - Toxic compound were not secured in the kitchen. -The provider did not have a laundry area to sort, process and store clean and soiled laundry and did not handle clean and soiled laundry in a way to prevent the spread of infection. - The provider did not have an emergency exit diagram in the facility. Personnel: - Two of 3 caregivers reviewed did not have documentation of a communicable disease screen, including tuberculosis test, completed upon hire. - Two of 3 caregivers reviewed did not receive training for challenging behaviors, client groups or resident rights before working alone in the facility. - Two of 3 caregivers reviewed did not receive training for personal cares and/or dietary tasks prior to completing such tasks. Resident Care: - Three of 3 residents did not have admission agreements. - One of 3 residents reviewed did not receive their medications as prescribed. - The provider did not provide adequate staff on a 24 hour basis to meet the need of the residents. The survey resulted in 15 deficiencies including: 83.15(3)(a) Administrator Shall Supervise Daily Operation 83.17(2)(a) Employees Screened for Communicable Disease Screen 83.22(1)-(4) Task Specific Training 83.28(3) Provide Admission Agreement As	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 214	Continued From page 2 Required 83.32(3)(h) Rights of Residents: Receive Medication 83.35(2) Temporary Service Plan 83.35(3)(c) Implement, Follow the Individual Service Plan 83.35(3)(d) Service Plans Updated Annually or on Changes 83.36(1)(a) Adequate Staff to Meet Resident Needsx 83.36(1)(b)4 Qualified Staff In Charge, On Duty and Awake 83.44(1)(a) Adequate Laundry Appliances Available 83.45(3) Toxic Substances 83.47(1)(c) Safety Requirements: No Safe Evacuation 83.47(2)(b) Exit Diagram 50.065(2)(b)intro Entity Background Check Requirements On 03/03/2025, at approximately 2:30 p.m., Surveyors reviewed the above concerns with Consultant D. Consultant D stated that the consultant company was assisting the licensee but they have been out of the building for a while and another administrator had been put in place. Consultant D stated s/he understands what needs to be done and the processes that need to be put in place to come into compliance.	N 214		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 220	Continued From page 3	N 220		

including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 caregivers reviewed, were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment. Caregiver A and Caregiver B were not screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment.

Findings include:

On 03/03/2025 at approximately 10:30 a.m., Surveyor requested an employee roster and records from Consultant D. Consultant D stated the roster on file was previous employees. Surveyor requested that employee roster and records, including staff screened for clinically apparent communicable disease, including tuberculosis be sent over by 2:00 p.m. on 03/04/2025.

On 03/04/2025 at 1:50 p.m., Surveyor received an email from Consultant E that requested an extension due to additional issues with administration. Surveyor gave extension of 12:00 p.m. on 03/05/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 220	Continued From page 4 On 03/05/2025 at 12:39 p.m. Consultant D sent employee records that did not include screenings for communicable disease, including tuberculosis tests for Caregiver A or Caregiver B. On 03/06/2025 at approximately 12:30 p.m., Surveyor requested screening for communicable disease, including tuberculosis tests for Caregiver A and Caregiver B be sent over by 5:00 p.m. on 03/06/2025. As of 5:32 p.m. Consultant E stated that they were unable to locate any further screens or tests.	N 220		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 247	Continued From page 5 training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees obtained all task specific training. Caregiver A and Caregiver B, who had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care prior to assuming these duties. Caregiver A and Caregiver B, who performed dietary duties, did not have training in dietary services within 90 days after assuming these job duties. Findings include: On 03/03/2025 at approximately 10:30 a.m., Surveyor requested an employee roster and records from Consultant D. Consultant D stated the roster on file was previous employees. Surveyor requested that employee roster and records, including task specific training for	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 247	Continued From page 6	N 247		

Caregiver A and Caregiver B be sent over by 2:00 p.m. on 03/04/2025.

On 03/04/2025 at 1:50 p.m., Surveyor received an email from Consultant E that requested an extension due to additional issues with administration. Surveyor gave extension of 12:00 p.m. on 03/05/2025.

On 03/06/2025 at approximately 12:30 p.m., Surveyor requested additional training documentation and staff schedule be sent for Caregiver A and Caregiver B be sent over by 5:00 p.m. on 03/06/2025. There was no additional task specific training found for Caregiver A or Caregiver B.

Provision of Personal Care

The record for Caregiver A, hired 02/26/2025, and Caregiver B, hired 02/05/2025, did not contain evidence of training or evidence of meeting an exemption for personal care training.

Dietary Training

The record for Caregiver A, hired 02/26/2025, and Caregiver B, hired 02/05/2025, did not contain evidence of training or evidence of meeting an exemption for dietary training.

On 03/12/2025 at approximately 9:00 a.m., Surveyor interviewed Consultant D after reviewing employee records and staff schedule. Consultant D stated that task specific training records for Caregiver A and Caregiver B were not found. Surveyor requested timecard documentation be sent for Caregiver A and Caregiver B.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 247	Continued From page 7 On 03/18/2025 at 1:36 p.m., Surveyor received an email with timecard documentation from Consultant D for Caregiver A and Caregiver B. Timecards indicated the following: -Caregiver A worked on 03/04/2025 from 7:30 a.m. to 3:00 p.m. -Caregiver B worked on 02/26/2025 from 10:45 p.m.-11:59 p.m., on 02/27/2025 from 12:00 a.m.-8:45 a.m., on 02/27/2025 from 9:00 p.m.-11:59 p.m., on 02/28/2025 12:00 a.m.-11:15 a.m., on 02/28/2025 6:45 p.m.-11:59 p.m., on 03/01/2025 12:00 a.m.-7:15 a.m., on 03/03/2025 from 11:15 p.m.-11:59 p.m., on 3/4/2025 12:00 a.m.-8:30 a.m., on 03/05/2025 12:15 a.m.-9:45a.m., and on 03/07/2025 11:00 p.m.-11:59 p.m., on 03/08/2025 12:00 a.m.-8:30 a.m. On 03/19/2025 at approximately 9:30 a.m., after Surveyor completed interview, observation and record review, it was determined that Caregiver A and Caregiver B worked at least 1 shift without completing training in task specific training. All employees must complete training in task specific training within 90 days of hire or before working alone.	N 247		
N 301	83.28(3) Provide admission agreement as required. Admission agreement. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29(2). This Rule is not met as evidenced by: Based on record review and interview, the	N 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 301	Continued From page 8	N 301		

provider did not ensure 3 of 3 residents were provided an admission agreement before or at the time of admission. Resident 1, Resident 2, and Resident 3 did not have an admission agreement from the current provider.

Findings include:

On 03/03/2025, Surveyor conducted a probationary licensing survey. The provider was licensed as a class CNA (nonambulatory) community based residential facility (CBRF) on 08/01/2024 with the ability to serve up to 8 residents within the client groups of: physically disabled, advanced age, traumatic brain injury, emotionally disturbed/mental illness, and irreversible dementia/Alzheimer's.

Example 1 - Resident 1
On 03/03/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 08/19/2014 with diagnosis including chronic brain injury, epilepsy with complex partial seizures and diabetes. Resident 1's admission agreement was dated 08/19/2014 and documented the services, fees, and general information and agreements from the previous owner of the facility.

Example 2 - Resident 2
On 03/03/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/10/2025 with diagnoses including cerebral palsy and quadriplegia. Resident 2 did not have an admission agreement.

Example 3 - Resident 3
On 03/03/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 3's record. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 301	Continued From page 9 3 was admitted to the provider on 09/10/2019 with diagnosis including muscular dystrophy, paranoid schizophrenia, anxiety, and depressive disorder. Resident 3's admission agreement was dated 09/12/2019 and documented the services, fees, and general information and agreements from the previous owner of the facility. At approximately 2:00 p.m., Surveyor reviewed the above concerns with Consultant D. Consultant D stated s/he was not in the building for a period of time, so s/he is unsure what the admission agreements weren't updated with the change in ownership, but that s/he has a plan in place to update them.	N 301		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received his/her sliding scale insulin as prescribed 4 times from 03/01/2025 to 03/03/2025. Findings include: On 03/03/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 07/24/2023 with diagnosis including chronic brain	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 352	Continued From page 10	N 352		

injury, epilepsy with complex partial seizures and diabetes. Resident 1's physician orders included:
-insulin aspart 100 unit/ml Pen, inject subcutaneously 8UN before breakfast *hold baseline if skips meals or BS <90* PLUS SS: <201=0UN; 201-250=2UN; 251-300=4UN; 301-350=6UN; >350=8UN.
-insulin aspart 100 unit/ml Pen, inject subcutaneously 8UN before lunch *hold baseline if skips meals or BS <90* PLUS SS: <201=0UN; 201-250=2UN; 251-300=4UN; 301-350=6UN; >350=8UN.
-insulin aspart 100 unit/ml Pen, inject subcutaneously 6UN before dinner *hold baseline if skips meals or BS <90 *PLUS SS: <201=0UN; 201-250=2UN; 251-300=4UN; 301-350=6UN; >350=8UN.
-insulin aspart 100 unit/ml Pen, inject subcutaneously one daily at bedtime based on sliding scale: <201=0UN; 201-250=2UN; 251-300=4UN; 301-350=6UN; 351-400=8UN; 401-450=10UN; 451-500=12 UN; >500=14UN.

Surveyor reviewed Resident 1's March 2025 medication administration record (MAR), which documented the following occurrences when Resident 1's sliding scale insulin was not administered as ordered:

-03/01/2025 at 7:54 a.m. Blood Sugar 219 - 3 additional units documented as administered. *Per order, 2 additional units of insulin should have been administered.
-03/01/2025 at 4:55 p.m. Blood Sugar 401 - 6 additional units documented as administered. *Per order, 8 additional units of insulin should have been administered.
-03/02/2025 at 11:46 a.m. Blood Sugar 371 - 6 additional units documented as administered. *Per order, 8 additional units of insulin should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 352	Continued From page 11 have been administered. -03/03/2025 at 6:51 a.m. Blood Sugar 380 - 6 additional units documented as administered. *Per order, 8 additional units of insulin should have been administered. At approximately 11:50 a.m., Surveyor interviewed Family Member F regarding Resident 1's diabetic diet. Family Member F had concerns about meals and stated staff do not know how to mix carbohydrates and proteins. Family Member F has provided protein shakes for when there are only carbohydrates for breakfast, but the facility has not used any, they are still in fridge. Family Member F stated s/he was concerned about Resident 1's current medication orders and whether or not the facility was administering the correct medication or not so s/he had the doctor cross reference medications because there have been so many changes and mistakes resulting in unregulated blood sugars and increased seizure activity. On 03/12/2025 at 10:25 a.m., Surveyor reviewed the above concerns with Consultant D. Consultant D acknowledged and understood that there were concerns with rights to receive medications.	N 352		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by:	N 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 385	Continued From page 12 Based on record review and interview, the provider did not ensure a temporary service plan was implemented for Resident 2 upon admission. Findings include: On 03/03/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/10/2025 with diagnoses including cerebral palsy and quadriplegia. Resident 2's record did not contain a temporary service plan upon admission. At approximately 2:00 p.m., Surveyor reviewed Resident 2's record with Consultant D, who confirmed there was no temporary service plan to review.	N 385		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not implement Resident 1's individual service plan (ISP) as written regarding his/her diabetic diet and seizure documentation. Findings include: On 03/03/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 07/24/2023 with diagnosis including chronic brain injury, epilepsy with complex partial seizures and type 1 diabetes. Resident 1 is his/her own	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 388	Continued From page 13 decision maker. Surveyor reviewed Resident 1's ISP, dated 09/10/2024. The ISP stated: -Diabetic - Staff Assistance - Resident requires staff to manage diabetes per physician orders. DIET: Regular, Diabetic diet. Resident is mostly independent with eating and is encouraged to follow a diabetic diet. Staff will offer resident 3 balanced meals & snacks with fluids each day. -Seizure Episode Monitoring - Staff will document seizures quantity & **FILL OUT REPORT & NOTIFY DIRECTOR OF ANY CONCERNS OR SEIZURE activity that does NOT resolve according to orders/care plan ASAP. Please follow attached seizure protocol. Surveyor reviewed Resident 1's progress notes and incident reports. There was no documentation of any seizures from December 2024 to March 2025. Surveyor reviewed Resident 1's hospital discharge summary which documented: -01/10/2025-01/13/2025, hospitalized after presenting with intractable generalized idiopathic epilepsy with status epilepticus and diabetes. -01/31/2025-02/03/2025, "[Resident 1] presented with breakthrough seizures, likely in the setting of severe hyperglycemia. ... Etiology of breakthrough seizure considered to possibly be hyperglycemia, with [his/her] poorly controlled DM Type 1. Hospitalization was complicated by significantly elevated blood glucose, into the 400s, for which [s/he] was placed on an insulin gtt, which was able to be discontinued 2/3 following an episode of hypoglycemia. [Resident 1] was discharged back to [his/her] assisted living facility in stable medical condition."	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 388	Continued From page 14 At approximately 11:50 a.m., Surveyor interviewed Family Member F regarding Resident 1's diabetic diet and seizures. Family Member F had concerns about meals and stated staff do not know how to mix carbohydrates and proteins. Family Member F has provided protein shakes for when there are only carbohydrates for breakfast, but the facility has not used any, they are still in fridge. Family Member F stated s/he has concerns that the facility calls 911 for Resident 1 even though s/he has a seizure disorder, and they should be following his/her seizure protocol. Family Member F stated s/he was concerned about Resident 1's current medication orders and whether or not the facility was administering the correct medication or not so s/he had the doctor cross reference medications because there have been so many changes and mistakes resulting in unregulated blood sugars and increased seizure activity. At 1:36 p.m., Surveyor interviewed Resident 1. Resident 1 stated s/he has been in and out of the hospital a lot recently due to a lot of uncontrolled seizure activity and high blood sugars. Resident 1 stated the facility provides a, "[expletive] diet. It's either all carbs or no carbs." Resident 1 went on to explain that is it terrible for a diabetic and that the protein to carbohydrate ratio s/he if offered at meals is not adequate to keep his/her blood sugars in control. On 03/03/2025 at approximately 2:30 p.m., Surveyor reviewed the above concerns with Consultant D. Surveyor asked to review Resident 1's seizure protocol, as it was not attached to the ISP. Consultant D stated yes, it does say that a seizure protocol should be attached, but that s/he could not find one.	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 389	Continued From page 15	N 389		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not update Resident 1's individual service plan (ISP) when there was a change in his/her needs and physical condition. Resident 1's ISP was not updated to reflect the current use of his/her helmet during transfers and while in his/her wheelchair or change in transfer status. Findings include: On 03/03/2025 at approximately 10:00 a.m., Surveyor observed Resident 1 in the common area, in his/her wheelchair without a helmet on. At approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 07/24/2023 with diagnosis including chronic brain injury, epilepsy	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 389	Continued From page 16	N 389		

with complex partial seizures and diabetes. Resident 1 is his/her own decision maker.

Surveyor reviewed Resident 1's ISP, dated 09/10/2024. The ISP states:
-Risk - Falls - Has a history of falls - due to self-transfers and not following safety plans *HIGH FALL RISK due to seizures *Velcro belt on wheelchair *Helmet to head for transfers and when in wheelchair, fall mat by bedside when in bed due to seizure activity or behavior & left side paralysis in 2006 due to diabetic coma/seizure disorder.
-Transferring - Mechanical Lift - Remind [Resident 1] to wait for staff for all transfers with lift to avail falls & injury [Resident 1] has history of impatient and trying to self transfer - be prompt with routine to avoid this occasion & remind [him/her] often NOTIFY MGMT if behaviors escalate and [s/he] is not waiting for staff!!! Resident required a mechanical lift for transfers. Transfers: Resident is a hoyer lift with all transfers, resident has a history of self transfers. Resident is to wear [his/her] helmet to head & padded gait belt but [s/he] often refuses or removes the gait belt and does self transfer instead of waiting for staff to use the sit to stand lift.

At 1:36 p.m., Surveyor interviewed Resident 1 who was sitting up in his/her wheelchair in his/her bedroom. Surveyor asked if Resident 1 was aware if s/he should be wearing a helmet while up in his/her wheelchair. Resident 1 became visibly upset and loudly stated, "no". Resident 1 stated that s/he does not need to wear a helmet when in his/her wheelchair and hasn't for a while now. Surveyor asked Resident 1 if s/he wears a helmet during transfers. Resident 1 again loudly stated, "no". Resident 1 stated that s/he does not wear a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 389	Continued From page 17 helmet at all anymore and has not for a very long time and that s/he is getting upset by Surveyor asking if s/he should. Surveyor asked Resident 1 if s/he ever attempts to self-transfer. Resident 1 stated no and asked Surveyor where this information was coming from stating, this is all very old and that s/he, "doesn't do this [expletive] anymore." Surveyor stated that s/he was reading from Resident 1's ISP and asked if that was not correct. Resident 1 stated no, it is not up to date and that the information is not current. On 03/03/2025 at approximately 02:30 p.m., Surveyor reviewed the above concerns with Consultant D. While Surveyor was reviewing the concerns with Consultant D, Resident 1 was sitting near Surveyor and became upset as evidence by him/her yelling in disagreement with what was written in his/her ISP, again stating s/he does not need a helmet and s/he will not wear it. Consultant D acknowledged that Resident 1's ISP was not updated to reflect his/her current needs and abilities.	N 389		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, record review and interview, the CBRF did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. The provider staffed the facility with 1 caregiver with 3 residents requiring 2 staff members to evacuate in case of an emergency.	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 396	Continued From page 18 Findings include: On 03/03/2025, at approximately 8:35 a.m., Surveyors entered the facility and observed Caregiver C was the only staff member in the facility. At approximately 9:00 a.m., Surveyor asked Caregiver C what the staffing patterns were for each shift. Caregiver C stated that there is one caregiver on first shift, one on second shift and one on third shift and that if anyone has off, the provider will use agency staff. At approximately 11:50 a.m., Surveyor interviewed Family Member F. Family Member F was concerned that there is only one caregiver on staff at the facility because Resident 1 requires a manual lift for transfers which s/he noted has appeared to be difficult with one staff. Family Member F showed surveyor that Resident 1's mechanical lift's battery is dead so Resident 1 often has to use a manual mechanical lift and s/he is afraid Resident 1 will fall if the staff can't crank and control Resident 1 at same time. Family Member F stated s/he has been at the facility and observed staff nearly drop Resident 1 out of the mechanical lift. At 1:36 p.m., Surveyor interviewed Resident 1 who was sitting up in his/her wheelchair in his/her bedroom. Surveyor asked Resident 1 if s/he is usually up in his/her wheelchair during the day or in bed. Resident 1 stated s/he is up in his/her wheelchair today because s/he had meetings with his/her care team, but typically s/he lays in bed. Surveyor asked Resident 1 if it is more comfortable for Resident 1 to be in bed. Resident 1 stated s/he would prefer to be up in his/her	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 396	Continued From page 19 wheelchair but staff have a hard time getting him/her into and out of his/her wheelchair with just one person, so it's easier to change him/her to keep him/her clean if s/he is in bed, so s/he stays there. Surveyor reviewed Resident 1's evacuation assessment which identified Resident 1 as having an evacuation time of over 4 minutes and needs limited assistance from two staff to evacuate. Surveyor reviewed Resident 2's evacuation assessment which identified Resident 2 as having an evacuation time of over 4 minutes and needs limited assistance from two staff to evacuate. Surveyor reviewed Resident 3's evacuation assessment which identified Resident 3 as having an evacuation time of over 4 minutes and needs limited assistance from two staff to evacuate. Surveyor reviewed the February and March staff schedule which documented that the provider staffs one caregiver for first, second and third shift. At approximately 2:30 p.m., Surveyor reviewed the above concerns with Consultant D. Consultant D stated s/he understands the concerns.	N 396		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 397	Continued From page 20 are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure that 2 of 3 employees reviewed had completed training in resident rights, client group or challenging behaviors before working alone in the facility. Caregiver A and Caregiver B did not have documented training in resident rights, client group or challenging behaviors, so there was not a qualifed resident care staff on duty for this shifts. Findings include: On 03/03/2025 at approximately 9:00 a.m., Caregiver C, who was the only staff member at the facility, wrote out a list of 3 employees that s/he identified worked at the facility. Surveyor asked what the staffing patters were for each shift. Caregiver C stated that there is one caregiver on first shift, one on second shift and one on third shift and that if anyone has off, the provider will use agency staff.	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 397	Continued From page 21 On 03/03/2025 at approximately 10:30 a.m., Surveyor requested an employee roster and records from Consultant D. Consultant D stated the roster on file was not up to date and was all previous employees. Surveyor requested that employee roster and records, including all staff training for Caregiver A and Caregiver B be sent over by 2:00 p.m. on 03/04/2025. On 03/04/2025 at 1:50 p.m., Surveyor received an email from Consultant E that requested an extension due to additional issues with administration. Surveyor gave extension of 12:00 p.m. on 03/05/2025. On 03/06/2025 at approximately 12:30 p.m., Surveyor requested additional training documentation and staff schedule be sent for Caregiver A and Caregiver B be sent over by 5:00 p.m. on 03/06/2025. There was no additional training found for Caregiver A or Caregiver B. Resident Rights The record for Caregiver A, hired 02/26/2025, did not contain evidence of training or evidence of meeting an exemption for resident rights. Surveyor asked Consultant D if there was any documentation to indicate Caregiver A had completed training in resident rights. Consultant D stated that s/he could not find any documentation that would indicate Caregiver A had completed training in resident rights. The record for Caregiver B, hired 02/05/2025, did not contain evidence of training or evidence of meeting an exemption for resident rights. Surveyor asked Consultant D if there was any documentation to indicate Caregiver B had	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 397	Continued From page 22	N 397		

completed training in resident rights. Consultant D stated that s/he could not find any documentation that would indicate Caregiver B had completed training in resident rights.

Recognizing, Preventing, Managing and Responding to Challenging Behaviors

The record for Caregiver A, hired 02/26/2025, did not contain evidence of training or evidence of meeting an exemption for resident rights. Surveyor asked Consultant D if there was any documentation to indicate Caregiver A had completed training in resident rights. Consultant D stated that s/he could not find any documentation that would indicate Caregiver A had completed training in challenging behaviors.

The record for Caregiver B, hired 02/05/2025, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors. Surveyor asked Consultant D if there was any documentation to indicate Caregiver B had completed training in challenging behaviors. Consultant D stated that s/he could not find any documentation that would indicate Caregiver B had completed training in challenging behaviors.

Client Group

The record for Caregiver A, hired 02/26/2025, did not contain evidence of training or evidence of meeting an exemption for client groups. Surveyor asked Consultant D if there was any documentation to indicate Caregiver A had completed training in client groups. Consultant D stated that s/he could not find any documentation that would indicate Caregiver A had completed training in client groups.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 397	Continued From page 23 The record for Caregiver B, hired 02/05/2025, did not contain evidence of training or evidence of meeting an exemption for client groups. Surveyor asked Consultant D if there was any documentation to indicate Caregiver B had completed training in client groups. Consultant D stated that s/he could not find any documentation that would indicate Caregiver B had completed training in client groups. On 03/12/2025 at approximately 9:00 a.m., Surveyor interviewed Consultant D after reviewing employee records and staff schedule. Consultant D stated that training records for Caregiver A and Caregiver B could not be found. Consultant D stated that s/he was not in place when these caregivers were hired and s/he understands that employees need to be fully trained before working alone in the facility. Surveyor requested timecard documentation be sent for Caregiver A and Caregiver B. On 03/18/2025 at 1:36 p.m., Surveyor received an email with timecard documentation from Consultant D for Caregiver A and Caregiver B. Timecards indicated the following: -Caregiver A worked on 03/04/2025 from 7:30 a.m. to 3:00 p.m. -Caregiver B worked on 02/26/2025 from 10:45 p.m.-11:59 p.m., on 02/27/2025 from 12:00 a.m.-8:45 a.m., on 02/27/2025 from 9:00 p.m.-11:59 p.m., on 02/28/2025 12:00 a.m.-11:15 a.m., on 02/28/2025 6:45 p.m.-11:59 p.m., on 03/01/2025 12:00 a.m.-7:15 a.m., on 03/03/2025 from 11:15 p.m.-11:59 p.m., on 3/4/2025 12:00 a.m.-8:30 a.m., on 03/05/2025 12:15 a.m.-9:45a.m., and on 03/07/2025 11:00 p.m.-11:59 p.m., on 03/08/2025 12:00 a.m.-8:30 a.m.	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 397	Continued From page 24 On 03/19/2025 at approximately 9:30 a.m., after Surveyor completed interview, observation and record review, it was determined that Caregiver A and Caregiver B worked at least 1 shift without completing training in resident rights, challenging behaviors and client groups which means there was not a qualified resident care staff on duty during those shifts.	N 397		
N 486	83.44(1)(a) Adequate laundry appliances available Laundry area. The CBRF shall make an adequate number of laundry appliances available to residents who choose to do their own laundry. The CBRF shall have a laundry area to sort, process and store clean and soiled laundry and shall handle clean and soiled laundry so as to prevent the spread of infection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not have a laundry area to sort, process and store clean and soiled laundry and handle clean and soiled laundry so as to prevent the spread of infection. Residents' soiled laundry was stored next to clean laundry in the laundry room. Findings include: On 03/03/2025, at approximately 9:25 a.m., Surveyor toured the facility's laundry room. Surveyor observed 4 laundry bins at different locations of the laundry room; 2 baskets full of laundry to the left of the washer, 1 basket full of laundry on top of the dryer, and 1 empty basket on the floor in front of the dryer. Surveyor asked Caregiver C to explain the facility's process of	N 486		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 486	Continued From page 25 doing laundry. Caregiver C stated some of the laundry had been washed and was waiting to be folded and some of the laundry was needing to be washed. Caregiver C explained that 1 of the baskets to the left of the washer was clean and 1 was dirty, the basket on top of the dryer was clean and the basket on the floor was waiting for the clean clothes to come out of the dryer. At approximately 2:30 p.m., Surveyors reviewed the above concerns with Consultant D. Consultant D acknowledged the concern of cross contamination in the laundry room.	N 486		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not secure cleaning compounds and toxic substances were stored in a secure area. Findings include: On 03/03/2025, Surveyor conducted a standard survey. The provider is licensed a class CNA (non-ambulatory) community based residential facility able to serve up to 8 residents within the Client groups of physically disabled, traumatic brain injury, advanced aged, emotionally disturbed/mental illness, and irreversible dementia/Alzheimer's. At approximately 9:20 a.m., Surveyor toured the	N 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 499	Continued From page 26 facility's kitchen. Surveyor observed a gallon of bleach, D-germ, glass cook top cleaner, and Easy Off stored in a kitchen cabinet underneath the sink. The cabinet was unable to be secured. Caregiver C stated that agency staff was working last night and that they may have taken out the cleaning supplies to clean and not put them away in the correct location. The cleaning supplies remained unsecured under the sink for the duration of the survey. Surveyor observed residents independently go into and out of the kitchen. At approximately 2:30 p.m., Surveyors reviewed the above concerns with Consultant D. Consultant D acknowledged the concern of cleaning compounds not being secured and stated s/he will remind all staff that cleaning supplies should be stored in the locked cleaning closet.	N 499		
N 521	83.47(1)(c) Safety requirements: no safe evacuation If a resident cannot be safely evacuated from their bedroom as determined by the CBRF ' s assessment, the CBRF shall instruct the resident to remain in the resident ' s bedroom and the CBRF shall meet all of the following requirements: 1. Be sprinklered as required under s. HFS 83.48(8). 2. Notify the local fire department and identify the specific residents using point of rescue, and provide an up-to-date floor plan identifying where those resident rooms are located. 3. Have vertical smoke separation between all floors. 4. Have 24 hour awake qualified resident care staff.	N 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 521	Continued From page 27 This Rule is not met as evidenced by: Based on record review and interview, the facility did not provide the fire department a floor plan which informed the department of 3 of 3 residents that were a point of rescue and where they were located in the facility. Findings include: On 03/03/2025, at 1:25 p.m., Surveyor toured the facility and observed the facility did not have exit diagrams posted near the exits. Surveyor reviewed Resident 1's evacuation assessment which identified Resident 1 as having an evacuation time of over 4 minutes and needing limited assistance from two staff to evacuate. Surveyor reviewed Resident 2's evacuation assessment which identified Resident 2 as having an evacuation time of over 4 minutes and needing limited assistance from two staff to evacuate. Surveyor reviewed Resident 3's evacuation assessment which identified Resident 3 as having an evacuation time of over 4 minutes and needing limited assistance from two staff to evacuate. Surveyor reviewed the facility's fire drills which document: No date documented - Time of day: 3:42 p.m. - Total Evacuation Time: 5 minutes 28 seconds - # of Staff: 4 Date: 09/20/2024 - Time of day: 9:52 a.m. Total Evacuation Time: 6 minutes 12 seconds - # of Staff: 4 At approximately 2:30 p.m., Surveyor reviewed the above concerns with Consultant D. Surveyor	N 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 521	Continued From page 28 asked Consultant D if the fire department had been updated with specific residents within the facility that are point of rescue. Consultant D stated s/he was unaware. On 03/12/2025, at 9:14 a.m., Surveyor asked the fire department had been in communication with the facility located at 825 Southbound Drive, DeForest, WI and whether or not they have identified specific residents within the facility that would be a point of rescue if there was a fire, and have provided an up-to-date floor plan identifying where those resident rooms are located? On 03/20/2025 at 9:58 a.m., Assistant Fire Chief G stated, "We have never had any communication on any point of rescue plans nor have we been given an up-to-date floor plan from the facility at 825 Southbound Dr." The provider did not provide the fire department with the required information regarding residents identified as point of rescue or the location of these residents in the facility. Residents were at risk for harm in the case evacuation was required in the event of a fire as the fire department was not made aware of the location of the residents requiring point of rescue. CROSS REFERENCE N0486 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs N0523 DHS 83.47(2)(b) Exit Diagram	N 521		
N 523	83.47(2)(b) Exit diagram. Exit diagram. The disaster plan shall have an exit diagram that shall be posted on each floor of the CBRF used by residents in a conspicuous	N 523		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
N 523	Continued From page 29 place where it can be seen by the residents. The diagram shall identify the exit routes from the floor, including internal horizontal exits under par. (f) when applicable, smoke compartments or a designated meeting place outside and away from the building when evacuation to the outside is the planned response to a fire alarm. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure an exit diagram identifying the emergency exit routes was posted at the exits of the facility. Findings include: On 03/03/2025, at 9:30 a.m., Surveyor toured the facility and observed the facility did not have exit diagrams posted near the exits. At 1:25 p.m., Surveyor requested Caregiver C tour facility with Surveyor and locate the posted exit diagrams. Surveyor and Caregiver C were unable to locate posted exit diagrams in the facility. On 03/03/2025 at 1:30 p.m., Surveyor shared concern of exit diagrams with Consultant D. Consultant D stated that the facility had diagrams a few months ago but was not sure what happened to the diagrams. Surveyor toured the facility with Consultant D and confirmed there were no exit diagrams posted in the facility.	N 523		
Z 005	50.065(2)(b)intro ENTITY BACKGROUND CHECK REQUIREMENTS 1. A criminal history search from the records maintained by the department of justice.	Z 005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
Z 005	Continued From page 30 2. Every entity shall obtain all of the following with respect to a caregiver of the entity: Information that is contained in the registry under s. 146.40(4g) regarding any findings against the person. 3. Information maintained by the department of safety and professional services regarding the status of the person's credentials, if applicable. 4. Information maintained by the department regarding any final determination under s. 48.981(3)(c)5m. or, if a contested case hearing is held on such a determination, any final decision under s. 48.981(3)(c)5p. that the person has abused or neglected a child. 5. Information maintained by the department under this section regarding any denial to the person of a license, certification, certificate of approval or registration or of a continuation of a license, certification, certificate of approval or registration to operate an entity for a reason specified in sub. (4m)(a)1. to 5. and regarding any denial to the person of employment at, a contract with or permission to reside at an entity for a reason specified in sub. (4m)(b)1. to 5. If the information obtained under this subdivision indicates that the person has been denied a license, certification, certificate of approval or registration, continuation of a license, certification, certificate of approval or registration, a contract, employment or permission to reside as described in this subdivision, the entity need not obtain the information specified in subds. 1. to 4.	Z 005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
Z 005	Continued From page 31	Z 005		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure all background information obtained on a caregiver was maintained. The provider did not maintain records for 2 of 3 caregivers reviewed. The provider did not have a completed Background Information Disclosure (BID) on file for Caregiver A or Caregiver B.

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 03/03/2025 at approximately 10:30 a.m., Surveyor requested an employee roster and records from Consultant D. Consultant D stated the roster on file was previous employees. Surveyor requested that employee roster and records, including background information, be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020255	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAYMOND HOUSE	825 SOUTHBOUND DRIVE DE FOREST, WI 53532

(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
Z 005	Continued From page 32 sent over by 2:00 p.m. on 03/04/2025. On 03/04/2025 at 1:50 p.m., Surveyor received an email from Consultant E that requested an extension due to additional issues with administration. Surveyor gave extension of 12:00 p.m. on 03/05/2025. On 03/05/2025 at 12:39 p.m. Consultant D sent employee records that included the background checks. - Caregiver A, no record of hire date, did not have a completed BID on file. Page 1 of the BID was the only page available to be reviewed. - Caregiver B, no record of hire date, did not have a completed BID on file. Page 1 of the BID was the only page available to be reviewed. On 03/06/2025 at approximately 12:30 p.m., Surveyor requested completed BIDs for Caregiver A and Caregiver B be sent over by 5:00 p.m. on 03/06/2025. As of 5:32 p.m. no additional information was sent over for completed BID's for Caregiver A or Caregiver B.	Z 005		