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
	0016415	A. BUILDING: _____ B. WING _____	R-C 08/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD ADULT FAMILY HOME LLC	2114 ORCHARD ST RACINE, WI 53405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	INITIAL COMMENTS On 08/06/2026 with information gathered through 08/10/2026, Surveyor conducted a standard survey, verification visit and 1 complaint investigation at Orchard Adult Family Home. One deficiency was identified. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{M 000}		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure provisions of individualized services specified that are the licensee's responsibility for 1 of 1 resident (Resident 1's) Individual Service Plan (ISP). Resident 1's ISP identified s/he needed supervision when eating due to disability that causes constant jerking, in uncontrollable movements. Findings include: On 09/26/2025 the Department received a self-report from the facility which confirmed	M 436		

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

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M 436	Continued From page 1 Resident 1 had passed away due to choking. The self-report stated, "[Caregiver C] went to front door and placed the soiled brief outside [they] turned around [Resident 1] was walking with [their] arms extended in the air. [Resident 1] was choking." On 11/19/2025, the Department received a complaint indicating a resident was not supervised while eating resulting in choking and passing away. On 08/06/2026 at approximately 12:00 PM, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 08/12/2021 with diagnoses that included Huntington's disease and anxiety. Resident 1's Individual Service Plan (ISP), dated 08/18/2025, stated "[Resident 1] requires assistance with eating meals due to [their] disability that causes constant jerking, in uncontrollable movements. Staff will assist [Resident 1] with liquid foods during mealtimes, [they] can eat most solid foods independently under staff supervision." On 08/10/2026 at approximately 12:30 PM, Surveyor interviewed Licensee A who confirmed Caregiver C had turned their back while putting a trash bag on the porch. Resident 1 then began choking. Licensee A confirmed staff were expected to supervise [Resident 1] but they normally just need help with liquids.	M 436		