STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 03/25/2026 with information gathered through 03/26/2026, Surveyor conducted a standard survey, at Edwards Residents, an Adult Family Home (AFH) in Milwaukee, WI. Thirteen deficiencies were identified. Census: 1	M 000		
M 204	88.03(8)(a) MONITORING OF HOME The licensee shall comply with all department and licensing agency request for information about residents, services or operation of the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not comply with Department requests for information during the survey process. Findings include: On 03/25/2026, at approximately 12:10 PM, Surveyor spoke with Administrator A over the phone while at the facility (due to Administrator A being out of town). Administrator A reported Licensee B and Caregiver C were service providers who provide direct care and supervision for Resident 1. Surveyor requested a resident roster, staff roster, Resident 1's service agreement, service providers (Licensee B and Caregiver C) training documentation and most recent furnace inspection from Administrator A.	M 204		

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
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 204	Continued From page 1 On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported s/he would email the resident roster, staff roster, Resident 1's service agreement, service providers (Licensee B and Caregiver C) training documentation and most recent furnace inspection to Surveyor by 5:00 PM. On 03/25/2026, at approximately 4:21 PM, Surveyor received an email from Administrator A reporting the following: "Hi, so as an FYI [for your information] I am working on all of the requested items [sic] but I am having a difficult time gathering it all before 5:00 PM. I will send all that I can." As of 03/26/2026 at 5:00 PM, Surveyor did not receive the requested resident roster, staff roster, Resident 1's service agreement, service providers (Licensee B and Caregiver C) training documentation and most recent furnace inspection. Cross Reference: M 0235 DHS 88.04(2)(h) Comply With Osha M 0244 DHS 88.04(5)(a) Training - 15 Hours Within 6 Months M 0246 DHS 88.04(5)(b) - Training - 8 Hours Annually M 0290 DHS 88.05(3)(e)2.b Inspections - Gas Furnace	M 204		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the	M 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 235	Continued From page 2 universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees reviewed received training in standard precautions as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens, prior to providing care to residents and annually. Licensee B and Caregiver C did not receive training in standard precautions annually for 2024 and 2025. The OSHA standard requires the employer train each employee with occupational exposure, "At the time of initial assignment to tasks where occupational exposure may take place" per 1910.1030(g) (2)(ii)(A); and "At least annually thereafter," per 1910.1030(g)(2)(ii) (B). Findings include: This facility was issued a non-ambulatory license on 06/02/2020 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, physically disabled and developmentally disabled. On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported Licensee B was a	M 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 235	Continued From page 3 service provider who provide direct care and supervision for Resident 1. On 03/25/2026, at approximately 12:10 PM, Surveyor requested Licensee B's training documentation from Administrator A. Administrator A reported s/he would email Licensee B's training documentation to Surveyor by 5:00 PM. On 03/25/2026, Surveyor reviewed Caregiver C's records and identified the following: -Caregiver C was hired on 10/01/2022 (according to Caregiver C's job description and responsibilities signature page signed and dated by Caregiver C). -Caregiver C's record did not have evidence of receiving standard precautions training in 2024 and 2025. On 03/25/2026, Surveyor reviewed Resident 1's record and identified the following : -Resident 1's Individual Service Plan, dated 01/26/2026, documented the following: "Toileting. Assistance needed: Full Assistance. Incontinence supplies used: wipes, bed pads and diapers." Licensee B and Caregiver C assisted Resident 1 with full assistance toileting needs. On 03/25/2026, at approximately 2:37 PM, Surveyor interviewed Administrator A. Administrator A reported s/he would email Caregiver C's training documentation to Surveyor by 5:00 PM. On 03/25/2026, at approximately 4:21 PM,	M 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 235	Continued From page 4 Surveyor received an email from Administrator A reporting the following: "Hi, so as an FYI [for your information] I am working on all of the requested items [sic] but I am having a difficult time gathering it all before 5:00 PM. I will send all that I can." As of 03/26/2026 at 5:00 PM, Surveyor did not receive Licensee B's and Caregiver C's standard precautions training documentation for 2024 and 2025.	M 235		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 service providers (Licensee B) received training within 6 months after starting to provide care related to health, safety and welfare of residents, resident rights and treatment appropriate to residents. Findings include: This facility was issued a non-ambulatory license	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 244	Continued From page 5 on 06/02/2020 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, physically disabled and developmentally disabled. On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported Licensee B was a service provider who provide direct care and supervision for Resident 1. On 03/25/2026, at approximately 12:10 PM, Surveyor requested Licensee B's training documentation from Administrator A. On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported s/he would email Licensee B's training documentation to Surveyor by 5:00 PM. On 03/25/2026, at approximately 4:21 PM, Surveyor received an email from Administrator A reporting the following: "Hi, so as an FYI [for your information] I am working on all of the requested items [sic] but I am having a difficult time gathering it all before 5:00 PM. I will send all that I can." As of 03/26/2026 at 5:00 PM, Surveyor did not receive Licensee B's training documentation related to health, safety and welfare of residents, resident rights and treatment appropriate to residents.	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 6 (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 each employee completed 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights, and treatment of residents for 2 of 2 service providers (Licensee B and Caregiver C) who required annual training. Licensee B and Caregiver C did not receive annual training in 2024 and 2025. Findings include: This facility was issued a non-ambulatory license on 06/02/2020 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, physically disabled and developmentally disabled. On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported Licensee B was a service provider who provide direct care and supervision for Resident 1. On 03/25/2026, at approximately 12:10 PM, Surveyor requested Licensee B's training	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 7 documentation from Administrator A. On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported s/he would email Licensee B's training documentation to Surveyor by 5:00 PM. On 03/25/2026, Surveyor reviewed Caregiver C's records and identified the following: -Caregiver C was hired on 10/01/2022 (according to Caregiver C's job description and responsibilities signature page signed and dated by Caregiver C). -Caregiver C's record did not have evidence of receiving annual training in 2024 and 2025 related to the health, safety, welfare, rights, and treatment of residents. On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported s/he would email Caregiver C's training documentation to Surveyor by 5:00 PM. On 03/25/2026, at approximately 4:21 PM, Surveyor received an email from Administrator A reporting the following: "Hi, so as an FYI [for your information] I am working on all of the requested items [sic] but I am having a difficult time gathering it all before 5:00 PM. I will send all that I can." As of 03/26/2026 at 5:00 PM, Surveyor did not receive Licensee B's and Caregiver C's annual training documentation for 2024 and 2025 related to the health, safety, welfare, rights, and treatment of residents.	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 8 CROSS REFERENCE M 235 88.04(2)(h) - Comply With Osha M 244 88.04(5)(a) - Training - 15 Hours Within 6 Months	M 246		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure there were two ramped exits to grade with a hard surfaced pathway with handrails from the facility for 1 of 1 resident (Resident 1) who utilized a wheelchair for mobility and received assistance from staff while	M 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 262	Continued From page 9	M 262		

ambulating. The provider also did not ensure all doorway clear openings were at least 32 inches for Resident 1's bedroom and doorway between hallway and dining room. Resident 1 utilized a wheelchair.

Findings include:

This facility was issued a non-ambulatory license on 06/02/2020 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, physically disabled and developmentally disabled.

On 03/25/2026, at approximately 12:43 PM, Surveyor toured the home and observed the following:

-The home is a three-bedroom, two family style duplex.

-The front exit door had one step to maneuver to get to ramp.

-The front exit ramp did not have a handrail on the right side of the ramp.

-At the end of the front exit ramp, there was approximately 18 inches where the ramp led to the grass and not a hard surfaced pathway.

-The rear exit had approximately three to five steps to maneuver to get to ground level sidewalk.

-The doorway between hallway and dining room had a clear opening of 28 inches.

On 03/25/2026, Surveyor reviewed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 262	Continued From page 10 department's electronic file for the facility. Surveyor located the facility floor plan. It indicated both the front and rear exits were emergency exits. On 03/25/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 05/05/2025 with diagnoses of Alzheimer's and fall risk. Resident 1's ISP, dated 01/26/2026, documented the following: "...Mobility. [Resident 1] needs assistance with mobility. [Resident 1] needs assistance with transferring. If yes to any of the above, describe needs: wheelchair and help by holding hands while walking. Additional Information: [Resident 1] has been in a slow decline with motor and muscle movements for several months now. [Resident 1] is a greater fall risk and [sic] to be assisted at all times when standing." On 03/25/2026, at approximately 2:52 PM, Surveyor interviewed Administrator A. Administrator A acknowledged the above-mentioned issues. Administrator A reported s/he was not aware of the above requirements. Administrator A reported s/he would inform Licensee B of the above-mentioned issues.	M 262		
M 270	88.05(2)(b) GRAB BARS IN TOILET AREA Grab bars shall be provided for toilet and bath fixtures in those bathing and toilet facilities used by residents not able to walk at all or only with difficulty, or by other residents with physical limitations that make transferring difficult.	M 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 270	Continued From page 11 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure grab bars were installed at bath fixtures for 1 of 1 bathroom. Findings include: This facility was issued a non-ambulatory license on 06/02/2020 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, physically disabled and developmentally disabled. On 03/25/2026, at approximately 12:56 PM, Surveyor observed 1 of 1 resident bathroom did not contain grab bars for the bathtub. On 03/25/2026, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 05/05/2025 with diagnoses of Alzheimer's and fall risk. -Resident 1's Member Centered Plan (from the Managed Care Organization), dated 11/11/2025, documented the following: "Bathing. Level of Assistance: Needs Assistance. Durable Medical Equipment (DME): Grab bars; shower chair. Comments: [Resident 1] requires assistance with bathing due to cognitive and physical impairment. [Resident 1] needs total assistance with all aspects of bathing tasks. Caregivers are providing the assistance. DME: Grab bar, shower chair. Falls Risk. Morse Fall Scale Score: High Fall Risk. Fall Prevention Interventions: DME education; medication review; appropriate footwear; ensure adequate lighting; remove clutter from home; caregiver assistance."	M 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 270	Continued From page 12 -Resident 1's ISP, dated 01/26/2026, documented the following: "Bathing. Full Care. [Resident 1] now requires help with all Activities of Daily Living basically. Mobility. [Resident 1] needs assistance with mobility. [Resident 1] needs assistance with transferring. If yes to any of the above, describe needs: wheelchair and help by holding hands while walking. Additional Information: [Resident 1] has been in a slow decline with motor and muscle movements for several months now. [Resident 1] is a greater fall risk and [sic] to be assisted at all times when standing." The provider did not ensure grab bars were installed at bath fixtures for 1 of 1 resident (Resident 1) who required DME (grab bars). On 03/25/2026, at approximately 12:57 PM, Surveyor interviewed Administrator A. Administrator A acknowledged Resident 1 had cognitive and physical impairments. Administrator A reported s/he was not aware of this code requirement.	M 270		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment.	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 276	Continued From page 13 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a clean, well-maintained and homelike environment. The home required cleaning and repairs. This had the potential to affect 1 of 1 resident residing in the home. Findings include: On 03/25/2026, at approximately 12:43 PM, Surveyor toured the home and observed the following: Resident 1's room -Door (when opened leads to bathroom) leveled door handles were loose. -Door (when opened leads to living room) had discoloration. -Wall venting was rusted and had discoloration. -Wall vent cover was not attached to wall. -Walls had the appearance of dirt build-up. -Light switch wall plate was cracked. -Door was being blocked by the living room couch. Bedroom 2 -Light switch wall plate had discoloration. -Ceiling had cracks. -Door had 1 leveled door handle hanging. -Door had missing leveled door handle. Bathroom -Walls showed significant signs of scraping. -Bathtub contained numerous dark scuff and scratch marks. -Bathtub contained a mop, bucket, shower chair and high-risk toilet seat. -Door and door frame showed significant scratches. -Door transition strip had discoloration.	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 276	Continued From page 14 -Wall vents were rusted and had discoloration throughout home. -Hardwood flooring had discoloration and significant scratches throughout home. -Door and door frames throughout home showed significant scratches. -Walls throughout home contained numerous dark scuff and scratch marks. -Walls throughout home showed significant signs of scraping. -Build in wood wall cabinet in living room had discoloration and cracked glass. -Front door transition strip had discoloration. -Pantry window blind slats were broken. Hallway near back exit -Walls contained numerous dark scuff and scratch marks. Basement -Area where furnace was located ceiling light fixture did not have a bulb (area was dark Surveyor had to use the flashlight from Department phone to see). -Cobwebs throughout. -Flooring contained scattered trash. On 03/25/2026, at approximately 2:52 PM, Surveyor interviewed Administrator A. Administrator A acknowledged the above-mentioned homelike environment issues. Administrator A reported s/he would inform Licensee B of the above-mentioned homelike environment issues to ensure they were addressed.	M 276		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE	M 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 290	Continued From page 15 A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure the gas furnace was inspected and serviced every 3 years by a heating contractor or local utility company for 1 of 1 furnace. Findings include: This facility was issued a non-ambulatory license on 06/02/2020 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, physically disabled and developmentally disabled. On 03/25/2026, Surveyor requested to review facility's most recent furnace inspection from Administrator A. On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would send the inspection report to Surveyor via email by 5:00 PM. On 03/25/2026, at approximately 4:21 PM, Surveyor received an email from Administrator A reporting the following: "Hi, so as an FYI [for your information] I am working on all of the requested items [sic] but I am having a difficult time gathering it all before 5:00 PM. I will send all that I can." As of 03/26/2026, Surveyor did not receive documentation of a furnace inspection for the	M 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 290	Continued From page 16 home.	M 290		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 fire extinguishers were inspected annually by an authorized dealer and had an attached tag showing the date of inspection. The fire extinguishers, located near the kitchen and in the basement did not have an attached tag showing the date of the last inspection.	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 332	Continued From page 17 Findings include: This facility was issued a non-ambulatory license on 06/02/2020 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, physically disabled and developmentally disabled. On 03/25/2026, at approximately 12:43 PM, Surveyor toured the home and observed the following: -Fire extinguishers located near the kitchen and in the basement did not have an attached tag showing the date of the last inspection. On 03/25/2026, at approximately 2:52 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was not aware of this requirement.	M 332		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in	M 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 334	Continued From page 18 the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in 1 of 7 required locations. There was no smoke detector at the head of open stairway leading to basement. The provider also did not ensure there was a smoke detector on the ceiling of family room and on the ceiling of each sleeping room for 3 of 7 required locations. Findings include: On 03/25/2026, at approximately 12:43 PM, Surveyor toured the home and observed the following: -The head of open stairway leading to basement did not contain a smoke detector. -The dining room smoke detector was placed on the wall. The ceiling of dining room did not contain a smoke detector. -The smoke detector located in Resident 1's room was placed on the wall. The ceiling of Resident 1's room did not contain a smoke detector. -The smoke detector in room 2 was placed on the wall. The ceiling of room 2 did not contain a smoke detector. On 03/25/2026, at approximately 2:52 PM, Surveyor interviewed Administrator A. Administrator A acknowledged the above-mentioned information. Administrator A	M 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 334	Continued From page 19 stated s/he was not aware of this requirement.	M 334		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on the record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) had a service agreement completed prior to admission. Resident 1's record did not contain a service agreement. Findings include: On 03/25/2026, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted on 05/05/2025. -Resident 1's record did not contain evidence of a service agreement. On 03/25/2026, Surveyor requested Resident 1's service agreement from Administrator A.	M 384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 384	Continued From page 20 On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would send Resident 1's service agreement to Surveyor via email by 5:00 PM. On 03/25/2026, at approximately 4:21 PM, Surveyor received an email from Administrator A reporting the following: "Hi, so as an FYI [for your information] I am working on all of the requested items [sic] but I am having a difficult time gathering it all before 5:00 PM. I will send all that I can." As of 03/26/2026, Surveyor did not receive Resident 1's service agreement.	M 384		
M 508	88.09(1)(d)10 MEDICATION RECORDS Medication records under s. HSS 88.07(3)(d) and (e). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Medication Administration Record (MARs) were kept for 1 of 1 resident. Resident 1's MARs from October 2025-March 2026 were not included in his/her record. Findings include: On 3/25/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/05/2025. Resident 1's record contained MARs from July 2025-September 2025. Resident 1's record did not include Resident 1's MAR from October 2025-March 2026.	M 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 508	Continued From page 21 On 03/25/2026, Surveyor requested Resident 1's MARS from October 2025-March 2026 from Administrator A. On 03/25/2026, at approximately 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported staff were responsible to administer Resident 1's medications. Administrator A stated s/he would send Resident 1's MARs to Surveyor via email by 5:00 PM. On 03/25/2026, at approximately 4:21 PM, Surveyor received an email from Administrator A reporting the following: "Hi, so as an FYI [for your information] I am working on all of the requested items [sic] but I am having a difficult time gathering it all before 5:00 PM. I will send all that I can." As of 03/26/2026, Surveyor did not receive Resident 1's MARS from October 2025-March 2026.	M 508		
Z 024	50.065(4m)(c) COMPLETE BACKGROUND INFORMATION DISCLOSURE If the background information form completed by a person under sub. (6) (am) indicates that the person is not ineligible to be employed or contracted with for a reason specified under par. (b) 1. to 5., an entity may employ or contract with the person for not more than 60 days pending the receipt of the information sought under sub. (2) (b). If the background information form completed by a person under sub. (6) (am) indicates that the person is not ineligible to be permitted to reside at an entity for a reason specified in par. (b) 1. to 5. and if an entity	Z 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 024	Continued From page 22 otherwise has no reason to believe that the person is ineligible to be permitted to reside at an entity for any of these reasons, the entity may permit the person to reside at the entity for not more than 60 days pending receipt of information sought under sub. (2) (am). An entity shall provide supervision for a person who is employed or contracted with or permitted to reside as permitted under this paragraph. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee (Caregiver C) reviewed had a background information disclosure (BID). At a minimum, a complete caregiver background check completed for a caregiver consists of the following three documents: - A completed DHS form F-82064, Background Information Disclosure (BID). - A response from the Department of Justice (DOJ), either - A "no record found" response or - A criminal record transcript. - A Governmental Findings Report (previously "IBIS letter") from DHS that reports the person's status, including administrative finding or licensing restrictions. Findings include: On 03/25/2026, Surveyor reviewed Caregiver C's record and identified the following:	Z 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017944	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS RESIDENTS	2513 NORTH 41ST STREET MILWAUKEE, WI 53210

(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 024	Continued From page 23 -Caregiver C was hired on 10/01/2022. -Caregiver C's record did not include a BID. -Caregiver C's record included a DOJ, dated 10/24/2022. -Caregiver C's record included a Governmental Findings Report, dated 10/24/2022. On 03/25/2026, at approximately 12:36 PM, Surveyor interviewed Administrator A. Administrator A reported s/he was responsible for completing background checks. Administrator A reported s/he did not know why Caregiver C's record did not contain evidence of a BID.	Z 024		