STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018183	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALIM HOME CARE	3350 SOUTH 84TH STREET MILWAUKEE, WI 53227

(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 04/30/2026, Surveyor concluded a standard survey at Salim Home Care. Eight deficiencies were identified. Census: 2	M 000		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation indicating staff had been screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service for 2 of 2 staff reviewed (Caregiver B and Caregiver C). Findings include: On 04/23/2026 at 1:40 p.m., Surveyor reviewed the following staff files:	M 232		

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

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M 232	Continued From page 1 Caregiver B was hired 05/25/2024. Caregiver B started working with the residents in the home on 05/31/2024. Caregiver B was screened for tuberculosis (TB) on 07/02/2024; however, the provider did not obtain documentation from a physician, a registered nurse, or a physician's assistant indicating Caregiver B had been screened for illness detrimental to residents, as required. Caregiver B's record did not contain a screening for communicable disease. Caregiver C was hired 05/24/2024. Caregiver C started working with the residents in the home on 06/03/2024. Caregiver C's record did not contain a TB skin test or a screening for other illnesses detrimental to residents, including TB, within 90 days before the start of providing service. On 04/23/2026 at 11:10 a.m., Surveyor interviewed Licensee A, who confirmed Caregiver B did not have his/her communicable disease screen completed within 90 days prior to the start of service. Caregiver C did not have a communicable disease screen or TB test completed within 90 days prior to the start of service. Licensee A stated, "I don't know what happened with these. I need to add this task to the new hire check off lists for the future."	M 232		
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	M 244		

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M 244	Continued From page 2 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 2 of 2 staff (Caregiver B and Caregiver C) received the required training related to resident rights within 6 months after starting to provide care. Caregiver B and Caregiver C had no evidence of resident rights training in their files. Findings include: On 04/23/2026 at 1:40 p.m., Surveyor reviewed the following staff files: Caregiver B was hired 05/25/2024. Caregiver B's file did not contain evidence s/he completed training related to resident rights prior to or within 6 months after starting to provide care on 05/31/2024. Caregiver C was hired 05/24/2024. Caregiver C's file did not contain evidence s/he completed training related to resident rights prior to or within 6 months after starting to provide care on 06/03/2024 On 04/23/2026 at approximately 11:30 a.m., Surveyor interviewed Licensee A, who confirmed s/he checked caregivers CBRF and CNA training before the caregivers started working on the floor. Licensee A confirmed s/he touched on resident rights. However, s/he did not document it as training.	M 244		

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M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and staff interview, 2 of 2 staff did not complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, and treatment of residents every year beginning with the calendar year after the year in which the initial training was received. Caregiver B and Caregiver C did not receive annual training in 2025. Findings include: On 04/23/2026 at 1:40 p.m., Surveyor reviewed the following staff files: Caregiver B was hired 05/25/2024. Caregiver B's record did not contain evidence of receiving continuing education training for the year 2025. Caregiver C was hired 05/24/2024. Caregiver C's record did not contain evidence of receiving continuing education training for the year 2025. On 04/23/2026 at approximately 11:30 a.m., Surveyor interviewed Licensee A. Licensee A	M 246		

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M 246	Continued From page 4 confirmed Caregiver B began providing cares in 05/31/2024. Licensee A confirmed Caregiver B and Caregiver C did not complete 8 hours of annual training in 2025. Licensee A explained s/he reviewed things in his/her staff meetings and provided binders on education for staff to review but did not document the time as continuing education. Licensee A stated s/he was going to work on improving training in the future.	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:	M 262		

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M 262	Continued From page 5 Based on observation and interviews, the provider did not ensure that 1 of 2 emergency exits used by residents had turn radius once they exited out the facility and onto the deck. Surveyor observed 2 of 3 residents utilized electric wheelchairs for mobility. Resident 1 could not maneuver his/her power wheelchair off the secondary exit door ramp. There was not enough turn radius. Findings include: On 04/23/2026, at approximately 9:45 a.m., Surveyor toured the home and observed the following: - The facility was located on the lower portion of an upper-lower duplex style building. The upper building was lived in by a private renter. The units are defined by Lower A (the licensed Adult Family Homes [AFH] downstairs) and Upper B (the upstairs, private renters). -The emergency exits were side by side doors located at the front of the facility, entering next to one another, and sharing a hallway. The two emergency exits came out onto a platform deck. Surveyor observed the platform deck in front of Lower A was larger and contained enough room for wheelchair turn radius. -Surveyor observed the platform deck in front of shared Upper B exit was smaller and did not appear to have a turn radius for a wheelchair. The deck on the Upper B side was enclosed by a railing. From the base of Upper B's front door to the stairs leading down to the sidewalk, Surveyor measured the platform deck at 4 feet. - Surveyor observed Resident 1 exit the Upper B	M 262		

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M 262	Continued From page 6 exit door with his/her electronic wheelchair. Surveyor observed the screen door swinging to the right of the Upper B exit door and toward Lower A's platform deck and blocking the egress path for Resident 1 to exit. Resident 1 turned to the left, where the deck was narrower and was enclosed by handrails. -Surveyor observed Manager B close the screen door behind Resident 1. Resident 1 attempted to turn his/her wheelchair to the right, and his/her foot hit the handrails. Resident 1 was unable to turn out of the platform deck outside of Upper B exit door. S/He had to back up and go back into the facility. -The posted exit plan identified the emergency exits as the two side by side doors located at the front of the facility. On 04/23/2026, at 10:05 a.m., Surveyor interviewed Resident 1, who stated s/he had never exited any other door in the facility. S/He only used the Lower A exit. On 04/23/2026, at 10:05 a.m., Surveyor interviewed Licensee A, who confirmed the Lower A exit and the Upper B exits were listed as emergency exits. Licensee A acknowledged the concern with Upper B as a secondary exit door. Licensee A stated, "[Resident 1] can get through that door when s/he is in his/her manual wheelchair."	M 262		
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		

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M 276	Continued From page 7	M 276		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure the home was well-maintained, clean and a homelike environment for 3 of 3 residents. The hallway walls were scuffed, the living room window screen was loose and shredded, and the flooring transition from the kitchen floor to the living room carpet was pulling away, leaving a lift.

Findings include:

On 04/23/2026, at approximately 9:45 a.m., Surveyor toured the home and observed the following:

Livingroom

-The small window's screen was shredded and half connected and half moving with the wind.

-The screen door window-screen was pulled away from the bottom left side of the door, near the hinges.

-The screen door had a large black-grey scuff approximately 12-inches up from the floor that spread across half of the door.

-The air vent, near the front door and on the floor, contained reddish brown spots consistent with rust.

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M 276	Continued From page 8 - The flooring transition from the kitchen floor to the living room carpet was pulling away, which lifted and exposed approximately 12 inches of a flooring underneath. Bathroom The ceiling vent in the bathroom contained a thick accumulation of substances consistent with lint and dirt. The vent on the wall contained reddish brown spots consistent with rust. The paint was cracking and falling off. Hallway and bedroom doors -The hallway was painted white. There were black scuff marks along the length of the hallway. The black scuff marks were prominently focused on the bottom and the middle of the walls and bedroom doors. The black scuff marks were consistent with the approximate size of a wheelchair scraping against the wall. There were also areas within the black scuff marks where the paint had been scraped off. On 04/23/2026, at 1:30 p.m., Surveyor interviewed Licensee A, who acknowledged Surveyor's observations. Licensee A reported s/he would ensure the home was maintained moving forward.	M 276		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a	M 380		

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M 380	Continued From page 9	M 380		

physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) had a health examination by a physician to identify health problems and received a communicable disease screening or tuberculosis (TB) test within 90 days prior to admission to the facility or within 7 days after admission.

Findings include:

On 04/23/2026 at 12:00 p.m., Surveyor reviewed Resident 1's record. The following was identified:

-Resident 1 moved into the facility 10/23/2021.

- Resident 1 had a TB test administered on 08/05/2022.

- Resident 1's file did not have a complete TB test.

-Resident 1's record did not contain evidence of a health examination 90 days prior to admission or within 7 days after.

On 04/28/2026 at 12:39 p.m., Licensee A faxed Resident 1's completed tuberculosis skin test and

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M 380	Continued From page 10 communicable disease screening dated 08/08/2022, which was 9 months and 6 days after his/her admission date. On 04/23/2026 at 1:15 p.m., Surveyor asked if a health examination and communicable disease screen along with a TB test had been completed. Licensee A stated s/he believed the TB test was completed. Licensee A stated Resident 1 had the TB test and communicable disease done before s/he had dental work done. Licensee A acknowledged that Resident 1's TB test and communicable disease screening was late.	M 380		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.	M 424		

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M 424	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview, the provider did not update the Individual Service Plan (ISP) every 6 months for 1 of 1 resident (Resident 2) and when the resident's needs or preferences changed. Resident 2's ISP was not reviewed for update every 6 months with his/her responsible party and case management team and did not include information relating to the outside services Resident 2 received. Findings include: On 04/28/2026 at 11:40 a.m., Surveyor reviewed resident records and identified the following: - Resident 1 was admitted on 10/23/2021 with diagnoses including Paralysis from spinal cord injury back and shoulder pain, generalized muscle weakness, and history of cerebrovascular accident (stroke/CVA). Resident 1 had an activated healthcare power of attorney (AHCPOA D). Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. -Resident 1 did not have a complete written assessment within 30 days after placement in his/her file. - Resident 1's original ISP was dated 10/24/2021. Resident 1's record did not contain evidence that his/her ISP was reviewed every 6 months by the resident, AHCPOA D or his/her MCO case managers to determine continued appropriateness of the plan and if s/he wanted to update the plan as necessary regarding his/her activities of daily living.	M 424		

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M 424	Continued From page 12 -At the end of Resident 1's ISP document, the ISP contained the following notes, signatures, and dates: -Licensee A signature on 10/24/2021. -Licensee A signature on 04/20/2022. Licensee A documented, "Interact with other staff and other resident @ (at) AFH (adult family home) [sic] going to physical therapy and going to day program." -Licensee A signature on 10/10/2022. "[Resident 1] needed reminders of inappropriate behaviors [sic] are towards [opposite sex]. [Sic] 2 [opposite sex] staff complained of feeling harassment in the workplace because of [Resident 1] comment about their body, clothing, and his/her sex life." Surveyor observed this documentation was handwritten on last page of Resident 1's ISP. -Licensee A signature on 03/21/2023. Licensee A documented, "[Resident 1] is encouraged to become more independent when it comes to self-care. [Resident 1] Needs constant reminders to perform self-care activities like brushing teeth and wash [sic] face. Staff have to remind him/her in the morning and at bedtime." -Licensee A signature on 09/20/2023- Licensee A documented, "[Resident 1] needs full care help with activities of daily living (ADLs). S/He needs constant reminders and redirections with washing face brushing teeth etc. (etcetera)." -Licensee A signature on 03/15/2024. Licensee A documented, "Baseline still the same. S/He has been active in going to day program two times a week and goes to physical therapy (PT)/occupational therapy (OT) weekly."	M 424		

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M 424	Continued From page 13 -Licensee A on 08/06/2024. "Licensee A wrote, "No changes." -Licensee A on 02/08/2024. "Licensee A wrote, "No changes." -Licensee A on 08/06/2025. "Licensee A wrote, "No changes." -Licensee A on 02/01/2026. "Licensee A wrote, "No changes. Working with therapy." On 04/28/2026 at 10:00 a.m., Surveyor interviewed Resident 1, who confirmed s/he went out for PT and OT. On 04/28/2026 at 10:30 a.m., Surveyor interviewed Licensee A, who reported it was his/her responsibility to ensure development of ISPs. Licensee A reported s/he reviewed the ISPs. S/He stated Resident 1 had some memory issues due to his/her CVA. Resident 1 had an AHCPOA. Licensee A reported stated Resident 1 started going to a day program in May of 2023 two times a week. S/he then started to go three times a week. However, s/he slowly stopped going because the center would not let him/her smoke. Licensee A acknowledged that Resident 1's ISP did not contain his/her day program or his/her occupational therapy and physical therapy visits. Licensee A reported s/he would ensure moving forward s/he would complete Resident 1's ISP with more detail and include his/her AHCPOA and MCO case managers.	M 424		
M 582	88.10(3)(q) Medications Medications. To receive all	M 582		

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SALIM HOME CARE	3350 SOUTH 84TH STREET MILWAUKEE, WI 53227

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M 582	Continued From page 14 prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 2) received all prescribed medications in the dosage as prescribed by the resident's physicians. Findings include: On 04/28/2026 at 10:40 a.m., Surveyor reviewed Resident 2's record. The following was identified: -Resident 2 was admitted on 11/20/2022 with diagnoses including bipolar disorder and chronic obstructive pulmonary disease. -Resident 2's physician order dated 04/02/2026 read, "Divalproex 125 mg (milligram) tablet, delayed release. Take three tablet's every morning and every evening." - Resident 2's April 2026 Medication Administration Record (MAR), dated 04/01/2026 to 04/10/2026, contained 'X's" where caregivers would initial to confirm administration of medication. Surveyor observed Caregivers initials on 04/11/2026 at 8:00 a.m.	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018183	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALIM HOME CARE	3350 SOUTH 84TH STREET MILWAUKEE, WI 53227

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M 582	Continued From page 15 On 04/28/2026 at 10:40 a.m., Surveyor interviewed Resident 2, who reported the facility had run out of his/her medication recently. Resident 2 stated s/he was out of the medication for five to six days and it affected his/her sleep. Resident 2 stated, "It's very frustrating." On 04/28/2026 at 11:30 a.m., Surveyor interviewed Licensee A, who stated that the physician faxes their orders straight to the facility pharmacy. Licensee A stated s/he was responsible for refilling Resident 2's bubble pack medications. S/He ordered the medications through the pharmacy, and they needed a refill. The pharmacy informed Licensee A that they could not get a hold of Resident 2's physician in time and Resident 2 ran out of medication. Licensee A confirmed divalproex was not administered from April 1st to April 10th. On 04/30/2026 at 12:30 p.m., Surveyor interviewed Pharmacist E, who stated the pharmacy received Resident 2's new prescription for refill of his/her divalproex every 30 days. They received a refill order on 02/25/2026 and dispensed a 30-day supply to the facility. Pharmacist E stated they should have received another prescription refill order on 3/25/2026. Pharmacist E stated they did not receive one until 04/02/2026. Then when they tried to process the request, there was a problem with Resident 2's insurance. According to the pharmacy records, the medication was delivered to the facility on 04/10/2026. Resident 2 went without his/her medication for 10 days.	M 582		