STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017562	A. BUILDING: _____ B. WING _____	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A GOLDEN STAR AFH I	4205 MONTEREY DR CALEDONIA, WI 53402

(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 05/05/2026, Surveyor completed an abbreviated survey at A Golden Star AFH 1. As a result, 4 deficiencies were identified. Census: 2	M 000		
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 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 1 of 2 caregivers received training in standard precautions annually, as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. Caregiver B did not receive training in standard precautions prior to starting to provide care. 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:	M 235		

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
	0017562	A. BUILDING: _____ B. WING _____	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A GOLDEN STAR AFH I	4205 MONTEREY DR CALEDONIA, WI 53402

(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 1 On 05/04/2026, at 1:30 PM, Surveyor reviewed Caregiver B's file. Caregiver B was hired on 05/21/2025. Surveyor was unable to locate evidence Caregiver B was trained in standard precautions. On 05/05/2026, at 4:00 PM Surveyor interviewed Licensee A. Licensee A confirmed caregivers may be exposed to bloodborne pathogens. Licensee A reported s/he was unaware of the code requirement to ensure standard precautions was completed prior to the start of providing services. Licensee A reported they did conduct a bloodborne pathogens training 3 months ago.	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 staff received of training related to first aid and fire safety, prior to or within 6 months of starting to provide care. Caregiver B did not receive training in first aid and fire safety.	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017562	A. BUILDING: _____ B. WING _____	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A GOLDEN STAR AFH I	4205 MONTEREY DR CALEDONIA, WI 53402

(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 2 Findings include: On 05/04/2026, at 1:30 PM, Surveyor reviewed Caregiver B's file. Caregiver B was hired on 05/21/2025. Surveyor was unable to locate evidence Caregiver was trained in first aid and fire safety. On 05/05/2026, at 4:00 PM Surveyor interviewed Licensee A and Administrator D. Administrator D reported staff complete all training with the lead staff in the home they were working in. Licensee A reported s/he would need to look into why Caregiver B's file did not indicate s/he was trained in first aid and fire safety.	M 244		
M 514	88.09(2)(a) SERVICE PROVIDER RECORD Service provider record. The licensee shall maintain and keep up to date a separate personnel record for each service provider. The licensee shall ensure that all service provider records are adequately safeguarded against destruction, loss or unauthorized use. A service provider record shall include all of the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all service provider records were adequately safeguarded against destruction, loss, or unauthorized use in 1 of 1 employee (Caregiver C). Findings include:	M 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017562	A. BUILDING: _____ B. WING _____	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A GOLDEN STAR AFH I	4205 MONTEREY DR CALEDONIA, WI 53402

(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 514	Continued From page 3 On 05/04/2026, at 1:30 PM, Surveyor reviewed Caregiver C's record. Caregiver C was hired on 09/30/2024. Caregiver C's record contained the following: - A background information disclosure (BID) dated 09/24/2024. - A Department of Justice (DOJ) report and Government Findings Report (GFR) dated 04/01/2025, which was 183 days after her/his hire date. - A screening for communicable diseases and tuberculosis (TB) dated 01/15/2025, which was 107 days after her/his hire date. On 05/05/2026, at 4:00 PM Surveyor interviewed Licensee A and Administrator D. Administrator D reported Caregiver C's file was destroyed in the flooding and documents needed to be redone. Administrator D reported Caregiver C backdated the BID to her/his hire date, but they were unable to backdate the DOJ and GFR. Administrator D reported s/he had everyone redo the communicable disease screening in January due to flooding.	M 514		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017562	A. BUILDING: _____ B. WING _____	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A GOLDEN STAR AFH I	4205 MONTEREY DR CALEDONIA, WI 53402

(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 570	Continued From page 4 because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure water temperatures were kept at a safe temperature for 1 of 1 bathroom. The hot water temperature in the resident bathroom was 120.9° Fahrenheit (F). Findings include: The facility was licensed as an ambulatory adult family home (AFH), serving up to 4 residents in client groups emotionally disturbed/mental illness, developmentally disabled, physically disabled, advanced age, traumatic brain injury, terminally ill, irreversible dementia/Alzheimer's, alcohol/drug dependent, and correctional clients. On 05/04/2026, at 1:00 PM, Surveyor tested the water temperature in the bathroom sink faucet. The water temperature was 120.9° F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017)	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017562	A. BUILDING: _____ B. WING _____	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A GOLDEN STAR AFH I	4205 MONTEREY DR CALEDONIA, WI 53402

(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 570	Continued From page 5 On 05/05/2026, at 4:00 PM Surveyor interviewed Licensee A and Administrator D. Licensee A, and Administrator D confirmed the code requirement. Licensee A reported they had maintenance check all water temperatures to ensure they were compliant. Licensee A reported s/he would ensure maintenance turned down the water heater.	M 570		