STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015330	A. BUILDING: _____ B. WING _____	R-C 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARINAS GROUP HOME	**5140 KINGS CIRCLE RACINE, WI 53406**

(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 04/22/2026 with information gathered through 05/26/2026, Surveyor conducted a standard survey and verification visit for SOD HP0P11, dated 01/05/2022, at Marinas Group Home, an Adult Family Home (AFH) in Racine, WI. Twenty deficiencies were identified. Two of the 20 deficiencies were repeat deficiencies, See Statement of Deficiency (SOD) HP0P12, dated 01/05/2022 and SOD TN4Q11, dated 01/28/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a	M 114		

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

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M 114	Continued From page 1 pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee (Caregiver F) reviewed had a background check. Caregiver F did not have a complete background check. 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 Department of Health Services (DHS) that reports the person's status, including administrative finding or licensing restrictions. Findings include:	M 114		

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M 114	Continued From page 2 On 04/22/2026, Surveyor reviewed Caregiver F's record and identified the following: -Caregiver F was hired on 03/13/2024. -Caregiver F's BID was completed and signed by him/her on 03/14/2024. -Caregiver F's DOJ record was requested and reported on 09/17/2024 and the following was identified: Licensee A entered the incorrect name for Caregiver F. -Caregiver F's Governmental Findings Report was requested and reported on 09/17/2024 and the following was identified: Licensee A entered the incorrect name for Caregiver F. On 05/26/2026, at approximately 8:07 AM, Surveyor interviewed Licensee A. Licensee A confirmed Caregiver F's name was incorrect. Licensee A reported s/he is responsible for running background checks. Licensee A reported s/he did not realize Caregiver F's name was incorrect when s/he ran Caregiver F's background check. Licensee A reported s/he used the name provided on Caregiver F's employment application.	M 114		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related	M 134		

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M 134	Continued From page 3 to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 incident was reported to the Department for Resident 5, when there was significant change in a resident's status. Resident 5 had a fall on 02/09/2026, and was taken to the hospital for treatment, and the provider did not report the incident to the Department. Resident 5 had the following diagnoses: Fall and nondisplaced fifth metatarsal fracture of the right foot. Findings include: On 04/22/2026, Surveyor reviewed Resident 5's record and identified the following: -Resident 5 was admitted to the provider's home on 11/22/2025. -Resident 5's hospital After Visit Summary, dated 02/09/2026-02/13/2026, stated the following: "Discharge Diagnosis. Principal Problem: Falls. Active Problem: Closed nondisplaced fracture of fifth metatarsal bone of right foot." -Resident 5's Incident Report, dated 02/09/2026, written by Licensee A, documented the following: "This morning I was in the kitchen and [Resident 5] was coming from [sic] bathroom [sic] came to the kitchen and [s/he] was trying to sit down [sic]	M 134		

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M 134	Continued From page 4 [s/he] had [his/her] walker behind [him/her] [sic] [s/he] was trying to grab it without looking and seen that [Resident 5] walker was going side ways [sic] I ran and grabbed [Resident 5] because [s/he] was falling and asked [him/her] if [s/he] was ok [s/he] said yes [sic] also I asked if [s/he] wanted to go to hospital and [s/he] said no after that [s/he] went to sit down in front room after a few minutes later I called 911 and sent [Resident 5] to [Emergency Room (ER)] also I notified [sic] [his/her] guardian [s/he] went to see [Resident 5] at the ER after 2 hours later they call back to let me know [s/he] [sic] admitted at ER [s/he] has a fracture on [his/her] right foot." On 04/22/2026, Surveyor completed a review of the Department facility folder. Surveyor did not observe any self-reports submitted to the Department in 2026. On 04/22/2026, at approximately 2:40 PM, Surveyor interviewed Licensee A. Licensee A reported s/he did not report Resident 5's fall to the Department. Licensee A reported s/he did not know DHS (Department of Health Services) Chapter 88 regulations.	M 134		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the home and its operation complied with this chapter and	M 216		

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M 216	Continued From page 5	M 216		

all other laws governing the home and its operations potentially affecting 4 of 4 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations. As a result of the verification visit, 20 deficiencies were identified. Two of the 20 deficiencies were repeat deficiencies. The provider did not follow special orders which resulted from previous Statement of Deficiency (SOD) HP0P11, dated 01/05/2022.

This is a repeat deficiency. See Statement of Deficiency (SOD) TN4Q11, dated 01/28/2022.

Findings include:

On 04/22/2026, Surveyor reviewed Department records and identified on 04/18/2022, SOD HP0P11 and a Notice and Order Letter containing special orders were issued to Licensee A via email with the following:

"Based on the results of the Department ' s investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Marinas Group Home:

1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., the licensee shall protect and promote each resident's right to live in a home that is safe and well-maintained. The licensee shall ensure any ramp installed for resident use will be designed and constructed to meet the current safety and accessibility standards.

WITHIN 45 DAYS of receipt of this notice, the licensee will develop and implement corrective

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M 216	Continued From page 6 measures to address the environmental safety issue identified in Statement of Deficiency (SOD) HP0P11. The licensee shall retain documentation, acceptable to the department, to verify the condition of risk violation has been corrected. Acceptable documentation may include invoices, receipts, service reports, or contracts. All documentation required by Order #1 will be made available to department representatives upon request." On 04/22/2026 with information gathered through 05/26/2026, Surveyor conducted a standard survey and verification visit for SOD HP0P11, dated 01/05/2022, at Marinas Group Home. As a result of the survey, the provider was issued 20 deficiencies. Two of the 20 deficiencies were repeat deficiencies. The following 20 deficiencies, which includes this violation, were identified: M 114 88.03(3)(b) - Criminal Records Check M 134 88.03(5)(e)1 - Significant Change To The Resident M 216 88.04(2)(a) - Responsibilities - This is a repeat deficiency. M 230 88.04(2)(f) - Condition Which Represents Risk Or Harm - This is a repeat deficiency. M 232 88.04(2)(g)1 - Health Screening For Staff M 244 88.04(5)(a) - Training - 15 Hours Within 6 Months M 246 88.04(5)(b) - Training - 8 Hours Annually M 262 88.05(2)(a) - Difficulty Walking M 276 88.05(3)(a) - Home Environment M 344 88.05(4)(d)2.a - Fire Safety Evacuation Plan Review M 380 88.06(2)(a) - Admission Health Exam M 384 88.06(2)(b) - Service Agreement Except Respite	M 216		

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M 216	Continued From page 7 M 386 88.06(2)(c) - Service Agreement Requirements M 404 88.06(3)(a) - Individual Service Plan & Assessment M 420 88.06(3)(d)5 - Signed Statement Of Agreement M 424 88.06(3)(f) - Review Of Isp M 456 88.07(2)(e) - Annual Health Exam M 458 88.07(3)(a) - Prescription Medications M 464 88.07(3)(d) - Medication - Written Order M 570 88.10(3)(l) - Safe Physical Environment On 05/06/2026, at approximately 1:39 PM, Surveyor interviewed Licensee A. Licensee A confirmed receipt of SOD HP0P11 and the accompanying Notice and Order Letter. Licensee A reported s/he did not follow special orders. Licensee A confirmed s/he did not ensure any ramp installed for resident use was designed and constructed to meet the current safety and accessibility standards. Licensee A reported s/he is working to ensure ramps installed for resident use will be designed and constructed to meet the safety and accessibility standards.	M 216		
{M 230}	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation and interview, the provider permitted the existence and continuation of conditions in the home placing the health, safety,	{M 230}		

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{M 230}	Continued From page 8 and welfare of 4 of 4 residents at substantial risk of harm. The ramp connected to the kitchen and descended into the dining room did not have edge protection and handrails. This is a repeat deficiency. See Statement of Deficiency HP0P11, dated 01/05/2022. Findings include: The home was licensed as a non-ambulatory adult family home caring for up to 4 residents in the client groups of emotionally disturbed/mental illness, physically disabled, advanced aged, terminally ill, irreversible dementia/Alzheimer's and developmentally disabled. On 04/22/2026, at approximately 9:34 AM, Surveyor toured the facility with Licensee A and observed the following: -The ramp connected to the home kitchen and descended into the dining room did not have edge protection and handrails. The rise was approximately 6 inches and the length of the ramp was approximately 5 feet. On 04/22/2026, at approximately 9:35 AM, Surveyor interviewed Licensee A. Licensee A acknowledged that the ramp did not have edge protection and handrails. Licensee A did not have an explanation as to why the ramp was not designed and constructed to meet the current safety and accessibility standards.	{M 230}		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a	M 232		

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M 232	Continued From page 9	M 232		

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 ensure 2 of 2 service providers (Licensee A and Caregiver F) were screened for illness detrimental to residents, including tuberculosis (TB).

Findings include:

This facility was issued a non-ambulatory license on 10/30/2014 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and developmentally disabled.

On 04/22/2026, at approximately 3:22 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was a service provider who provide direct care and supervision for residents.

On 04/22/2026, Surveyor reviewed Licensee A's and Caregiver F's records and identified the following:

Licensee A

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M 232	Continued From page 10 -Licensee A's record did not contain documentation s/he was screened for illness detrimental to residents or TB results. Caregiver F -Caregiver F was hired on 03/13/2024. -Caregiver F's employee record did not contain documentation s/he was screened for illness detrimental to residents. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed his/her record did not contain documentation of being screened for illness detrimental to residents or TB test results. Licensee A confirmed Caregiver F's record did not contain documentation of being screened for illness detrimental to residents. Licensee A reported moving forward s/he will ensure staff are screened for illness detrimental to residents, including TB. On 05/02/2026, at approximately 4:43 PM, Surveyor received an email from Licensee A. Documentation in email identified the following: -Licensee A was screened for illness detrimental to residents on 04/29/2026 (7 days after start of survey). -Licensee A TB skin test results were dated 05/01/2026 (9 days after start of survey).	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	M 244		

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M 244	Continued From page 11	M 244		

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 2 of 2 service providers (Licensee A and Caregiver F) 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 on 10/30/2014 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and developmentally disabled.

On 04/22/2026, at approximately 3:22 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was a service provider who provide direct care and supervision for residents.

On 04/22/2026, Surveyor reviewed Licensee A's and Caregiver F's records and identified the following:

Licensee A
-Licensee A's record did not contain evidence of

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M 244	Continued From page 12 training related to health, safety and welfare of residents, resident rights and treatment appropriate to residents. Caregiver F -Caregiver F was hired on 03/13/2024. -Caregiver F's record did not contain evidence of training related to health, safety and welfare of residents and treatment appropriate to residents. On 04/22/2026, Surveyor requested training documentation for Licensee A and Caregiver F from Licensee A. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A reported s/he would email training documentation to Surveyor by 8:00 AM on 04/23/2026. As of 05/26/2026, at 5:00 PM, Surveyor did not receive evidence of the above-mentioned training documentation for Licensee A and Caregiver F.	M 244		
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.	M 246		

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M 246	Continued From page 13	M 246		

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, welfare, rights, and treatment of residents for 2 of 2 service providers (Licensee A and Caregiver F) who required annual training.

Licensee A did not receive annual training related to health and welfare of residents in 2024.
Licensee A did not receive annual training related to health, welfare, resident rights and treatment of residents in 2025.

Caregiver F did not receive annual training related to health, welfare, resident rights and treatment of residents in 2025.

Findings include:

This facility was issued a non-ambulatory license on 10/30/2014 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and developmentally disabled.

On 04/22/2026, at approximately 3:22 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was a service provider who provide direct care and supervision for residents.

On 04/22/2026, Surveyor reviewed Licensee A's and Caregiver F's records and identified the following:

Licensee A
-Licensee A's record did not contain evidence of training related to health and welfare of residents

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(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 14 in 2024. -Licensee A did not receive annual training related to health, welfare, resident rights and treatment of residents in 2025. Caregiver F -Caregiver F was hired on 03/13/2024. -Caregiver F's record did not contain evidence of training related to health, welfare, resident rights and treatment of residents in 2025. On 04/22/2026, Surveyor requested training documentation for Licensee A and Caregiver F from Licensee A. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A reported s/he would email training documentation to Surveyor by 8:00 AM on 04/23/2026. As of 05/26/2026, at 5:00 PM, Surveyor did not receive evidence of the above-mentioned annual training documentation for Licensee A and Caregiver F. CROSS REFERENCE 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:	M 262		

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M 262	Continued From page 15 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 4 of 4 residents (Resident 3, Resident 4, Resident 5 and Resident 6) reviewed. Resident 3 and Resident 6 utilized a wheelchair for mobility and received assistance from staff while ambulating. Resident 4 utilized a cane for mobility and received assistance from staff while ambulating. Resident 5 utilized a walker for mobility and received assistance from staff while ambulating. Findings include: This facility was issued a non-ambulatory license on 10/30/2014 to serve up to 4 residents within	M 262		

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M 262	Continued From page 16	M 262		

the following client groups: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and developmentally disabled.

On 04/22/2026, at approximately 9:34 AM, Surveyor toured the facility with Licensee A and observed the following:

-The home is a three-bedroom, single family home.

-There was one step from living room to maneuver into dining room.

-Exit 1 ramp in garage was made from wood 2 by 4's and was missing transition piece. The ramp did not have handrails. The garage floor sunk in 1inch below the threshold of the exit door.

-Exit 2 door leading to ramp had a 1-inch gap from the flooring of door that transition piece did not cover. From the bottom looking up the right side of ramp had a 1/2-inch lift and did not have handrails.

On 04/22/2026, Surveyor reviewed residents records and identified the following:

Resident 3
-Resident 3 was admitted to the provider's home on 09/07/2021 with a diagnosis of fall risk. Resident 3's Individual Service Plan (ISP), dated 01/20/2026, documented the following: "[Resident 3] uses a manual wheelchair and walker for ambulation due to weakness and unsteadiness, and risk for falls. [Resident 3] is able to propel [his/her] wheelchair. [Resident 3] may need reminders regarding safety precautions such as using breaks due to cognitive deficits resulting

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M 262	Continued From page 17 from dementia." Resident 4 -Resident 4 was admitted to the provider's home on 02/23/2023 with a diagnosis of fall risk. Resident 4's ISP, dated 12/04/2024, documented the following: Medical Equipment: Cane. Alert: Fall risk." Resident 5 -Resident 5 was admitted to the provider's home on 11/22/2025. Residents 5's Managed Care Organization placement summary, dated 09/12/2025, documented the following: "Equipment needed for mobility and transfers: [Resident 5] uses a walker. [Resident 5] prefers someone be close by transferring as [s/he] is afraid [s/he] is going to fall. Mobility: [Resident 5] needs cues and assistance to use [his/her] [Durable Medical Equipment] DME with mobility related to [his/her] cognitive limitations. [Resident 5] at times is unsteady on [his/her] feet related to [his/her] arthritis and needs assistance. DME: Walker." Resident 6 -Resident 6 was admitted to the provider's home on 03/02/2026 with a diagnosis of fall risk. Resident 6's ISP, dated 03/02/2026, documented the following: "Mobility: [Resident 6] is able to propel [his/her wheelchair. [Resident 6] is able to propel independently on good days but needs assistance on days with increased weakness and fatigue which happens 3 days a week. [Resident 6] requires assistance to safely ambulate some of the time." On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A acknowledged the above-mentioned issues.	M 262		

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M 262	Continued From page 18 Licensee A confirmed Resident 3 and Resident 6 utilized a wheelchair for mobility. Licensee A confirmed Resident 4 utilized a cane for mobility and Resident 5 utilized a walker for mobility. Licensee A reported s/he would ensure the above-mentioned issues are corrected.	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. 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 walls, wall trimming, doors and doorframes showed signs of scraping throughout the home. Living room flooring showed significant signs of peeling. Flooring between living room and kitchen had missing transition piece. Wall vent in kitchen was rusted and caked with a substance consistent to dust. Ceiling fan in kitchen was caked with a substance consistent to dust. Wood baseboard diffuser in kitchen had broken wood. Door frames throughout home had missing flooring. The bathroom had missing wall trimming, sink vanity wood was peeling, sink vanity had missing wood, window and windowsill had peeling and chipped paint interior and exterior, tissue fixture was missing the inner roller, wall vent was rusted and	M 276		

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M 276	Continued From page 19	M 276		

caked with a substance consistent to dust, trimming along shower contained a black substance consistent with black mold and bathroom light fixture was caked with a substance consistent to dust. Flooring underneath the dishwasher in kitchen had food debris buildup. There was caked up lint behind dryer in basement. This had the potential to affect 4 of 4 residents residing in the home.

Findings include:

On 04/22/2026, at approximately 9:34 AM, Surveyor toured the facility with Licensee A and observed the following:

-Walls throughout home showed significant signs of scraping.

-Living room flooring showed significant signs of peeling.

-Flooring between living room and kitchen had missing transition piece.

-Wall vent in kitchen was rusted and caked with a substance consistent to dust.

-Ceiling fan in kitchen was caked with a substance consistent to dust.

-Wood baseboard diffuser in kitchen had broken wood.

-Wall trimming showed significant signs of scraping throughout home.

-Door and door frames throughout home showed significant scratches.

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M 276	Continued From page 20 -Door frames throughout home had missing flooring. -Bathroom had missing wall trimming throughout. -Bathroom sink vanity wood was peeling. -Bathroom sink vanity had missing wood consistent to being rot and water damage. -Bathroom window and windowsill had peeling and chipped paint interior and exterior. -Bathroom tissue fixture was missing the inner roller. -Bathroom wall vent was rusted and caked with a substance consistent to dust. -Bathroom walls showed significant signs of scraping. -Trimming along shower contained a black substance consistent with black mold. -Bathroom light fixture was caked with a substance consistent to dust. -Flooring underneath the dishwasher in kitchen had food debris buildup. -There was caked up lint behind dryer in basement. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A stated s/he was aware of the home environment issues throughout the home. Licensee A reported s/he would ensure the homelike environment issues were addressed.	M 276		

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M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents (Resident 6) reviewed were evaluated within 3 days of admission for evacuation time, using the department's form, for evacuation. Findings include: On 04/22/2026, Surveyor reviewed Resident 6's record and identified the following: -Resident 6 was admitted to the provider's home on 03/02/2026. -Resident 6's record did not have evidence of a fire safety evacuation plan completed within 3 days of admission. On 04/22/2026, at approximately 9:06 AM, Survey requested Resident 6's evacuation assessment from Licensee A. Licensee A reported s/he would send documentation to Surveyor by 8:00 AM on 04/23/2026. On 05/02/2026, at approximately 4:43 PM,	M 344		

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M 344	Continued From page 22 Surveyor received an email from Licensee A stating per Surveyor request, attached Surveyor will find the request files. Documentation in email identified the following: -Resident 6's Resident Evacuation Assessment, dated 04/16/2026, listed the evaluator as Licensee A, page 5 of 5 documented the following: "Evaluator's Remarks: [Resident 3] is ambulatory but is unable to evacuate the home in case of an emergency under 2 minutes with assistance of a assistive device. [Resident 3] is very limited and moves very slowly. [Resident 3] will need full assistance to get help into [his/her] wheelchair to evacuate to home safely. However, [Resident 3] is able to propel wheelchair. [Resident 3] will remain in the designated area once brakes are locked on [his/her] wheelchair. [Resident 3] is a Point of Rescue." Resident 6's Evacuation Evaluation identified individual specific information about Resident 3. Resident 6's Resident Evacuation Assessment, dated 04/16/2026, was incomplete due to Resident 3's information being documented on page 5 of 5 of Resident 6's Resident Evacuation Assessment.	M 344		
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 physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a	M 380		

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M 380	Continued From page 23	M 380		

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 4 of 4 residents (Resident 3, Resident 4, Resident 5 and Resident 6) reviewed received a health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission or within 7 days after admission.

Resident 3 and Resident 6 were not screened for communicable disease.

Resident 4 was not screened for communicable disease, including TB skin test.

Resident 5 did not have a health exam, including a screening for communicable disease, including TB skin test.

Findings include:

On 04/22/2026, Surveyor reviewed resident records and identified the following:

Resident 3
-Resident 3 was admitted to the provider's home on 09/07/2021.

-Resident 3's record did not include evidence of a communicable disease screening.

Resident 4
-Resident 4 was admitted to the provider's home

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M 380	Continued From page 24 on 02/23/2023. -Resident 4's record did not include evidence of a communicable disease screening, including TB skin test. On 04/22/2026, at approximately 9:06 AM, Survey requested Resident 4's communicable disease documentation from Licensee A. Licensee A reported s/he would send documentation to Surveyor by 8:00 AM on 04/23/2026. On 05/08/2026, at approximately 9:34 AM, Surveyor received an email from Licensee A stating per Surveyor request, attached Surveyor will find the request files. Documentation in email identified the following: -A letter from Resident 4's doctor, dated 04/30/2026 (8 days after start of survey), stated the following: "This letter is to verify that my patient, [Resident 4], is free of communicable disease with no induration of PPD place on 04/27/2026." Resident 5 -Resident 5 was admitted to the provider's home on 11/22/2025. -Resident 5's record did not include evidence of a health exam, including a screening for communicable disease, including TB skin test. On 04/22/2026, at approximately 9:06 AM, Survey requested Resident 5's health exam, communicable disease screening, including TB skin test documentation from Licensee A. Licensee A reported s/he would send documentation to Surveyor by 8:00 AM on	M 380		

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M 380	Continued From page 25 04/23/2026. As of 05/26/2026, at 5:00 PM, Surveyor did not receive evidence of the above-mentioned documentation for Resident 5. Resident 6 -Resident 6 was admitted to the provider's home on 03/02/2026. -Resident 6's record did not include evidence of a communicable disease screening. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 3's and Resident 6's records did not have documentation they were screened for communicable disease. Licensee A stated moving forward s/he will ensure residents received a health exam, including a screening for communicable disease, including TB skin test.	M 380		
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.	M 384		

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M 384	Continued From page 26 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 residents (Resident 6) reviewed had a service agreement completed signed and dated by the licensee, resident, or resident's guardian or designated representative prior to admission. Findings include: On 04/22/2026, Surveyor reviewed Resident 6's record and identified the following: -Resident 6 was admitted to the provider's home on 03/02/2026. -Resident 6 had an activated healthcare power of attorney (POA). -Resident 6's record did not contain evidence of a service agreement. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 6's record did not contain evidence of a service agreement. Licensee A reported s/he gave Resident 6's POA the service agreement to review and sign and had not received it back from POA.	M 384		
M 386	88.06(2)(c) SERVICE AGREEMENT REQUIREMENTS A service agreement shall specify all of the following: This Rule is not met as evidenced by:	M 386		

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M 386	Continued From page 27 Based on record review and interview, the provider did not ensure 2 of 3 residents (Resident 3 and Resident 4) reviewed service agreements specified the following: charges for room and board and services and source. Findings include: On 04/22/2026, Surveyor reviewed Resident 3's and Resident 4's records and identified the following: Resident 3 -Resident 3 was admitted to the provider's home on 09/07/2021. -Resident 3's service agreement did not specify the following: charges for room and board and services and source. Resident 4 -Resident 4 was admitted to the provider's home on 02/23/2023. - Resident 4's service agreement did not specify the following: charges for room and board and services and source. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 3's and Resident 4's service agreement did not specify the following: charges for room and board and services and source. Licensee A stated moving forward s/he will ensure residents service agreement includes the above-mentioned information.	M 386		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT	M 404		

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M 404	Continued From page 28 The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents (Resident 5) reviewed had a written assessment and individual service plan (ISP) completed and developed within 30 days after admission. Findings include: On 04/22/2026, Surveyor reviewed Resident 5's record and identified the following: -Resident 5 was admitted to the provider's home on 11/22/2025. -Resident 5's record did not contain a written assessment and individual service plan (ISP). The assessment and individual service plan (ISP) was not completed and developed within 30 days after admission. On 04/22/2026, at approximately 9:06 AM, Survey requested Resident 5's assessment and ISP from Licensee A. Licensee A reported s/he would send documentation to Surveyor by 8:00 AM on 04/23/2026. As of 05/26/2026, at 5:00 PM, Surveyor did not receive Resident 5's assessment and ISP.	M 404		

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(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 420	Continued From page 29	M 420		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents (Resident 6) individual service plan (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 6's ISP did not include a signed statement of agreement with all parties involved. Findings include: On 04/22/2026, Surveyor reviewed Resident 6's record and identified the following: - Resident 6 was admitted to the provider's home on 03/02/2026. - Resident 6 had an activated healthcare power of attorney (POA). - Resident 6's ISP, dated 03/02/2026 did not contain his/her POA signature. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 6's ISP needed to be signed by all parties in agreement with the plan. Licensee A reported s/he gave Resident 6's ISP	M 420		

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	0015330	A. BUILDING: _____ B. WING _____	R-C 05/26/2026

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M 420	Continued From page 30 to his/her POA to review and sign and had not received it back.	M 420		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents (Resident 4) reviewed had his/her Individual Service Plan (ISP) reviewed every 6 months to determine continued appropriateness of the plan and to update the plan as necessary. Findings include: On 04/22/2026, Surveyor reviewed Resident 4's	M 424		

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M 424	Continued From page 31 record and identified the following: -Resident 4 was admitted to the provider's home on 02/23/2023. -Resident 4 had an activated healthcare power of attorney (POA). -There was no evidence Resident 4's ISP was reviewed and updated after 12/04/2024. At minimum, Resident 4's ISP should have been reviewed and updated in June 2025 and December 2025. On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A stated s/he was the one who completed the ISP updates. Licensee A confirmed s/he was aware Resident 4's ISP should have been reviewed at least once every 6 months to determine continued appropriateness of the plan and to update the plan as necessary. Licensee A stated moving forward s/he will ensure residents ISPs were reviewed at least once every 6 months to determine continued appropriateness of the plan and to update the plan as necessary.	M 424		
M 456	88.07(2)(e) ANNUAL HEALTH EXAM The licensee shall ensure that each resident has an annual health exam by a physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents (Resident 3) reviewed had an annual health exam by a physician. There was no record of an annual health exam for Resident 3 in 2024 and 2025.	M 456		

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M 456	Continued From page 32 Findings include: On 04/22/2026, Surveyor reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 09/07/2021. -Resident 3's record did not contain an annual health exam for Resident 3 in 2024 and 2025. On 04/22/2026, at approximately 9:06 AM, Survey requested Resident 3's annual exam for 2024 and 2025 from Licensee A. Licensee A reported s/he would send documentation to Surveyor by 8:00 AM on 04/23/2026. On 05/08/2026, at approximately 9:34 AM, Surveyor received an email from Licensee A stating per Surveyor request, attached Surveyor will find the request files. Documentation in email identified the following: -Resident 3's medical service appointment report, dated 05/06/2026 (14 days after start of survey), documented Resident 3 had a wellness and routine checkup.	M 456		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	M 458		

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M 458	Continued From page 33	M 458		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure all medication was securely stored. Resident 6's medication was not securely stored in the home's refrigerator.

Findings include:

This facility is licensed as a non-ambulatory home to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and developmentally disabled.

On 04/22/2026, at approximately 3:59 PM, Surveyor observed a brown envelope labeled refrigerate upon arrival on the shelf of the home's refrigerator. Inside of the brown envelope Surveyor observed the following:

Resident 6
-Insulin Glargine-YFGN U100 inject 28 units into the skin nightly. Prime 2 units before each dose (1 pen).

-Novolog Flexpen Syringe blood sugar 150-201 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301 + give 8 units, 3 times daily with meals as needed. Max 8 units. Prime 2 units before each dose (5 pens).

On 04/22/2026, at approximately 4:15 PM,

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M 458	Continued From page 34 Surveyor interviewed Licensee A. Licensee A confirmed the brown envelope containing Resident 6's medication was not securely stored in the home's refrigerator. Licensee A went into the home's basement to get a lock box to lock Resident 6's medication while Surveyor was still onsite.	M 458		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician specifying who by name or position could administer medications for 2 of 4 residents (Resident 5 and Resident 6) reviewed who required staff to administer his/her medications. Resident 5 and Resident 6 did not have a written order permitting the provider staff to administer medications. Findings include: On 04/22/2026, Surveyor reviewed resident	M 464		

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M 464	Continued From page 35 records and identified the following: Resident 5 -Resident 5 was admitted to the provider's home on 11/22/2025. -Resident 5 did not have an order specifying who by name or position could administer his/her medication. On 04/22/2026, at approximately 9:06 AM, Survey requested Resident 5's written order permitting the provider staff to administer medications from Licensee A. Licensee A confirmed Resident 5 required staff to administer his/her medication and s/he would send documentation to Surveyor by 8:00 AM on 04/23/2026. On 05/08/2026, at approximately 9:34 AM, Surveyor received an email from Licensee A stating per Surveyor request, attached Surveyor will find the request files. Documentation in email identified the following: -Resident 5's medication authorization from Resident 5's doctor, dated 05/04/2026 (12 days after start of survey), stated the following: "To whom it may concern: with this signed letter, please be advised I have given permission to the employees of [this facility] to administer medications to my patient [Resident 5]." Resident 6 -Resident 6 was admitted to the provider's home on 03/02/2026. -Resident 6 did not have an order specifying who by name or position could administer his/her medication.	M 464		

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M 464	Continued From page 36 On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 6 required staff to administer his/her medication. Licensee A confirmed Resident 6's record did not contain evidence of a written order permitting the provider staff to administer medications from the physician.	M 464		
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 because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not safeguard residents who cannot fully guard themselves from environmental hazards. The concrete in the garage (Exit 1) showed signs of being unleveled and cracking. The concrete near ramp landing (Exit 1 and Exit 2) showed signs of being unleveled and cracking. Findings include: This facility was issued a non-ambulatory license	M 570		

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M 570	Continued From page 37 on 10/30/2014 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and developmentally disabled. On 04/22/2026, at approximately 9:34 AM, Surveyor toured the facility with Licensee A and observed the following: -The concrete in the garage (Exit 1) showed signs of being sunken, unleveled and cracking approximately 1 inch below the threshold of the exit door. -The concrete near ramp landing (Exit 1 and Exit 2) showed signs of being unleveled and cracking. On 04/22/2026, Surveyor reviewed residents' records and identified the following: Resident 3 -Resident 3 was admitted to the provider's home on 09/07/2021 with a diagnosis of fall risk. Resident 3's Individual Service Plan (ISP), dated 01/20/2026, documented the following: "[Resident 3] uses a manual wheelchair and walker for ambulation due to weakness and unsteadiness, and risk for falls. [Resident 3] is able to propel [his/her] wheelchair. [Resident 3] may need reminders regarding safety precautions such as using breaks due to cognitive deficits resulting from dementia." Resident 4 -Resident 4 was admitted to the provider's home on 02/23/2023 with a diagnosis of fall risk. Resident 4's ISP, dated 12/04/2024, documented the following: Medical Equipment: Cane. Alert: Fall risk."	M 570		

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M 570	Continued From page 38 Resident 5 -Resident 5 was admitted to the provider's home on 11/22/2025. Residents 5's Managed Care Organization placement summary, dated 09/12/2025, documented the following: "Equipment needed for mobility and transfers: [Resident 5] uses a walker. [Resident 5] prefers someone be close by transferring as [s/he] is afraid [s/he] is going to fall. Mobility: [Resident 5] needs cues and assistance to use [his/her] [Durable Medical Equipment] DME with mobility related to [his/her] cognitive limitations. [Resident 5] at times is unsteady on [his/her] feet related to [his/her] arthritis and needs assistance. DME: Walker." Resident 6 -Resident 6 was admitted to the provider's home on 03/02/2026 with a diagnosis of fall risk. Resident 6's ISP, dated 03/02/2026, documented the following: "Mobility: [Resident 6] is able to propel [his/her wheelchair. [Resident 6] is able to propel independently on good days but needs assistance on days with increased weakness and fatigue which happens 3 days a week. [Resident 6] requires assistance to safely ambulate some of the time." On 04/22/2026, at approximately 4:15 PM, Surveyor interviewed Licensee A. Licensee A acknowledged the above-mentioned issues. Licensee A confirmed Resident 3 and Resident 6 utilized a wheelchair for mobility. Licensee A confirmed Resident 4 utilized a cane for mobility and Resident 5 utilized a walker for mobility. Licensee A reported s/he would ensure the above-mentioned issues are corrected.	M 570		