STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 05/06/2026, Surveyor conducted a standard survey at Allysons Adult Home II. As a result, 9 deficiencies were identified. Census: 2	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 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	M 114		

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
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 114	Continued From page 1 license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers (Caregiver B and Caregiver C) had a completed background check within 60 days of employment. Caregiver B's background check was completed 258 days after her/his start of employment. Caregiver C's background check was completed 212 days prior to her/his start of employment. Findings include: On 05/06/2026, at 1:30 PM, Surveyor reviewed staff files and identified the following: - Caregiver B was hired on 01/03/2025. Caregiver B's Background Information Disclosure (BID) form was dated 09/18/2025. Caregiver B's Department of Justice (DOJ) and Government Findings Report (GFR) were dated 09/18/2025, which was 258 days after the start of employment. Surveyor was unable to locate evidence of a completed background check when Caregiver B started her/his employment. - Caregiver C was hired on 04/18/2026. Caregiver C's DOJ and GFR were dated 09/18/2025, which was 212 days prior to her/his start of employment. Surveyor was unable to locate Caregiver C's BID form. Surveyor was unable to locate evidence of a completed background	M 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 114	Continued From page 2 check around the time when Caregiver C started employment. On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A did not offer an explanation of why Caregiver B's background was not completed at the time of employment. Licensee A reported Caregiver C was a rehire. Licensee A reported Caregiver C was previously employed at the facility and left for approximately a year. Licensee A reported Caregiver was going to come back in September 2025 but ended up coming back in April 2026.	M 114		
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 ensure 2 of 2 caregivers (Caregiver B and Caregiver C) were screened for communicable diseases, including tuberculosis (TB), within 90 days before the start of providing	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 232	Continued From page 3 cares. Caregiver B was screened for TB and communicable diseases 479 days after the start of providing care. Caregiver C was screened for TB 1,478 days before the start of providing cares. Caregiver C was not screened for communicable diseases. Findings include: On 05/06/2026, at 1:30 PM, Surveyor reviewed staff files and identified the following: - Caregiver B was hired on 01/03/2025. Caregiver B was screened for TB and communicable diseases on 04/27/2026, which was 479 days after the start of providing care. - Caregiver C was hired on 04/18/2026. Caregiver C was screened for TB on 04/01/2022, which was 1,478 days after the start of providing cares. Caregiver C's record did not evidence Caregiver B was screened for communicable diseases. On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he was unaware the communicable disease screening was separate from TB. Licensee A reported s/he thought Caregiver C's TB screening was still valid since s/he was a rehire. Licensee A reported Caregiver B worked off and on when s/he needed help. Licensee A acknowledged Surveyors concerns.	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 4 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 training related to first aid, prior to or within 6 months of starting to provide care. Caregiver B did not receive training in first aid. Findings include: On 05/06/2026, at 1:30 PM, Surveyor reviewed Caregiver B's file. Caregiver B was hired on 01/03/2025. Surveyor was unable to locate evidence Caregiver was trained in first aid. On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he thought Caregiver B had all her/his training.	M 244		
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	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 344	Continued From page 5 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 2 of 2 residents were evaluated for fire evacuation to determine whether the resident was able to evacuate the home without any assistance within 2 minutes. Resident 1 and Resident 2 were not evaluated for fire evacuation. Findings include: On 05/06/2026, at 1:00 PM, Surveyor reviewed resident records and identified the following: Resident 1 was admitted in 2022 (exact date is unknown). Resident 1's record did not contain evidence Resident 1 was evaluated for fire evacuation. Resident 2 was admitted on 06/16/2025. Resident 2's record did not contain evidence Resident 2 was evaluated for fire evacuation. On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was unaware of the code requirement. Licensee A reported s/he would need to complete the evaluations.	M 344		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 346	Continued From page 6 the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 1 of 1 resident (Resident 1) who lived in the facility beyond one year. Resident 1 annual evacuation assessment was not completed in 2023, 2024, 2025 and to date in 2026. Findings include: On 05/06/2026, at 1:00 PM, Surveyor Resident 1's record. Resident 1 was admitted in 2022 (exact date unknown). Resident 1's record did not contain evidence of completed annual evacuation assessments for Resident 1 in 2023, 2024, 2025 and to date in 2026. On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was unaware of the code requirement. Licensee A reported s/he would need to complete the evaluations.	M 346		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30	M 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 404	Continued From page 7 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written assessment, and an individual service plan (ISP) were developed for 2 of 2 residents within 30 days after placement. Resident 1 did not have a written assessment, or an ISP completed within 30 days. Resident 2 did not have a completed written assessment or an ISP completed within 30 days. Findings include: On 05/06/2026, at 1:00 PM, Surveyor reviewed resident records and identified the following: Resident 1 was admitted on unknown date in 2022 with diagnoses including anxiety. Resident 2 was her/his own person. Resident 1's record did not contain a written assessment or ISP. Resident 2 was admitted on 06/16/2025, with diagnoses including depression and anxiety. Resident 2 was her/his own person. Resident 2's record contained a written assessment, which was undated. Resident 2's record did not contain an ISP. On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A confirmed Resident 1 had lived in the facility for several years. Licensee A reported s/he does develop ISPs for residents. Licensee A confirmed s/he did not develop ISPs for Resident 1 and Resident 2. Licensee A did not offer an explanation to why the ISPs were not	M 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 404	Continued From page 8 developed for Resident 1 and Resident 2. Licensee A reported s/he would ensure the ISPs were developed immediately.	M 404		
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 who prescribed medications to the resident, stating who can administer the medications for 2 of 2 resident. Resident 1's and Resident 2's record did not contain a written order to administer medications. Findings include: On 05/06/2026, at 1:00 PM, Surveyor reviewed resident records and identified the following: Resident 1 was admitted in 2022 with diagnoses including anxiety. Resident 1's member centered plan (MCP) developed by the managed care organization (MCO), dated 09/01/2025, indicated	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 464	Continued From page 9 Resident 1 required assistance with medication administration. Resident 1's record did not contain evidence of a written order for staff to administer medications to Resident 1. Resident 2 was admitted on 06/16/2025, with diagnoses including depression and anxiety. Resident 2's MCP, developed by the MCO, dated 08/01/2025, indicated Resident 2 required assistance with medication administration. Resident 2's record did not contain evidence of a written order for staff to administer medications to Resident 2. On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1 and Resident 2 required assistance with medication administration. Licensee A reported s/he just learned about the written order the week prior from an MCO. Licensee A reported s/he would ensure the written orders were obtained.	M 464		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 resident (Resident 1 and Resident 2) records contained all required information and were maintained in a secure location within the home.	M 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 482	Continued From page 10 Findings include: On 05/06/2026, at 1:00 PM, Surveyor reviewed resident records and identified the following: Resident 1 was admitted in 2022 with diagnoses including anxiety. Surveyor was handed a 3-ring binder for Resident 1. The binder was disorganized, and documents were mixed together and placed in the plastic folder parts on the front and rear cover verses inside the 3 ring binders. -Resident 1 was admitted in 2022. Resident 1's record did not contain the following documents: Date of admission Admission health exam Communicable disease screening and TB test Service/Admit Agreement Resident 2 was admitted on 06/16/2025, with diagnoses including depression and anxiety. Surveyor was handed a manilla folder for Resident 2. The manilla folder was disorganized and papers were mixed together. Surveyor was unable to find documents in Resident 2's file. - Resident 2 was admitted on 06/16/2025. Resident 2's record did not contain the following documents: Admission health exam Communicable disease screening and TB test Complete Service/Admit Agreement On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A acknowledged Surveyor's concerns regarding ensuring resident files were completed. Licensee A reported there	M 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 482	Continued From page 11 were items which needed to be developed, and s/he needed to become more organized to ensure documentation was readily available.	M 482		
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 and interview, the provider did not ensure a safe physical environment for 2 of 2 residents. The hot water temperature was 155.3° Fahrenheit (F). The dryer vent was not connected to the dryer or the outside exhaust vent. Findings include: On 05/06/2026, at 1:25 PM, Surveyor toured the facility and observed the following: - Surveyor tested the water temperature. The water temperature was 155.3° F. - The dryer vent was not connected to the back of the dryer. The top of the vent was leaning against	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016469	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLYSONS ADULT HOME II	3600 10TH AVE RACINE, WI 53403

(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 12 the wall, not connected to the outside exhaust vent. Surveyor observed thick dust-like substance, consistent with lint all over the wall. Numerous cobwebs were present on the walls and were covered in a thick, dust-like substance, consistent with lint. "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) On 05/16/2026, at 2:15 PM, Surveyor interviewed Licensee A. Licensee A reported they tested the water daily. Licensee A reported s/he would ensure the water heater was turned down, and the dryer vent was reconnected.	M 570		