

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 01/29/2026
NAME OF PROVIDER OR SUPPLIER FIVE GOOD MEN COMMUNITY GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 942 NORTH 29TH STREET MILWAUKEE, WI 53208		
(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 01/29/2026, Surveyors conducted a verification visit for SOD MLRZ11, dated 08/05/2025, at Five Good Men Community Group Home LLC, an Adult Family Home (AFH) in Milwaukee, WI. Fifteen of 15 deficiencies were corrected for SOD MLRZ11. No deficiencies identified. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 1	{M 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE