| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017931 | A. BUILDING: _____ B. WING _____ | 04/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RELENTLESS CARE LLC | 4303 N 66TH ST MILWAUKEE, WI 53216 |

| (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 |
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| M 000 | INITIAL COMMENTS<br><br>On 04/02/2026 with information gathered through 04/07/2026, Surveyor conducted a standard survey, at Relentless Care LLC, an Adult Family Home (AFH) in Milwaukee, WI.<br><br>Sixteen deficiencies were identified.<br><br>Census: 3 | M 000 | | |
| M 134 | 88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT<br><br>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 to use of a physical restraint or psychotropic medications, was a suicide or was accidental.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 2 incidents were reported to the Department for Resident 3, when there was significant change in a resident's status. Resident 3 had a fall on 10/13/2025 and 01/12/2026, and was taken to the hospital for treatment, and the provider did not report the incident to the Department.<br><br>Resident 3 had the following diagnoses: Laceration of buttock and fall (occurred from 10/13/2025 fall). | M 134 | | |

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

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| M 134 | Continued From page 1<br><br>Resident 3 had the following diagnoses: Face laceration and fall (occurred from 01/12/2026 fall).<br><br>Findings include:<br><br>On 04/02/2026, Surveyor reviewed Resident 3's record and identified the following:<br><br>-Resident 3 was admitted to the provider's home on 12/04/2024.<br><br>-Resident 3's hospital After Visit Summary, dated 10/13/2025, stated the following: "Reason for visit: Fall. [Resident 3's] diagnoses: Laceration of buttock and fall."<br><br>-Resident 3's incident Report, dated 10/13/2025, documented the following: "[Resident 3] fell on [his/her] buttock causing a tear or cut in [his/her] rectum that resulted in bleeding. [Resident 3] had fallen due to getting off the toilet and tripping. [Resident 3] did not injure any other part of [his/her] body."<br><br>-Resident 3's hospital After Visit Summary, dated 01/12/2026, stated the following: "Reason for visit: Fall and laceration. [Resident 3's] diagnoses: Laceration of forehead, contusion of face and fall."<br><br>-Resident 3's incident Report, dated 01/12/2026, documented the following: "[Resident 3] was reaching for [his/her] mirror and comb and bumped [his/her] head and was bleeding from [his/her] head."<br><br>On 04/02/2026, Surveyor completed a review of the Department facility folder. Surveyor did not | M 134 | | |

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| M 134 | Continued From page 2<br>observe any self-reports submitted to the Department in 2025 or 2026.<br><br>On 04/02/2026, at approximately 6:28 PM, Surveyor interviewed Licensee A. Licensee A reported s/he did not report Resident 3's falls to the Department. Licensee A reported s/he did not know DHS (Department of Health Services) Chapter 88 regulations. | M 134 | | |
| M 232 | 88.04(2)(g)1 HEALTH SCREENING FOR STAFF<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 3 service providers (Manager B, Caregiver C and Caregiver D) reviewed were screened for illness detrimental to residents. Manager B's, Caregiver C's and Caregiver D's employee records did not contain documentation of being screened for illness detrimental to residents.<br><br>Findings include: | M 232 | | |

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| M 232 | Continued From page 3<br><br>On 04/03/2026, Surveyor reviewed service providers records and identified the following:<br><br>Manager B<br>-Manager B was hired on 02/02/2022. Manager B's employee record did not contain documentation s/he was screened for illness detrimental to residents.<br><br>Caregiver C<br>-Caregiver C was hired on 08/15/2025. Caregiver C's employee record did not contain documentation s/he was screened for illness detrimental to residents.<br><br>Caregiver D<br>-Caregiver D was hired on 12/14/2025. Caregiver D's employee record did not contain documentation s/he was screened for illness detrimental to residents.<br><br>On 04/03/2026, at approximately 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported Manager B was also a service provider who provide direct care and supervision for Resident 1, Resident 2 and Resident 3. Licensee A confirmed Manager B's, Caregiver C's and Caregiver D's employee records did not contain documentation of being screened for illness detrimental to residents. Licensee A reported s/he was not aware service providers needed to be screened for illness detrimental to residents. | M 232 | | |
| M 235 | 88.04(2)(h) COMPLY WITH OSHA<br><br>The licensee and all service providers involved in the operation of the adult family home shall comply with the | M 235 | | |

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| M 235 | Continued From page 4<br>universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 employee reviewed received training in standard precautions as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens, prior to providing care to residents and annually. Manager B did not receive training in standard precautions annually for 2024 and 2025.<br><br>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).<br><br>Findings include:<br><br>This facility was issued an ambulatory license on 07/23/2020 to serve up to 3 residents within the following client groups: developmentally disabled, correctional clients, alcohol/drug dependent, traumatic brain injury and emotionally disturbed/mental illness.<br><br>On 04/02/2026, Surveyor completed a review of the Department facility folder and identified the following: | M 235 | | |

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| M 235 | Continued From page 5<br><br>-On 08/03/2022, the Department granted a license amendment to increase capacity and the addition of client groups for this facility. The maximum number of residents who may live in this facility is 4. The client group including: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and/or dually diagnosed, alcohol/drug dependent, correctional clients, traumatic brain injury, developmentally disabled, pregnant women/counseling and terminally ill.<br><br>On 04/03/2026, at approximately 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported Manager B was also a service provider who provide direct care and supervision for Resident 1, Resident 2 and Resident 3.<br><br>On 04/03/2026, Surveyor reviewed Manager B's record and identified the following:<br><br>-Manager B was hired on 02/02/2022.<br><br>-Manager B's record did not have evidence of receiving standard precautions training in 2024 and 2025.<br><br>On 04/03/2026, at approximately 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported Manager B worked directly with residents to meet all their needs including incontinence cares. Licensee A confirmed Manager B did not receive standard precaution training in 2024 and 2025. Licensee A confirmed Manager B may encounter bloodborne pathogen while conducting his/her duties. | M 235 | | |

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| M 262 | Continued From page 6 | M 262 | | |
| M 262 | 88.05(2)(a) DIFFICULTY WALKING<br><br>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:<br>1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails.<br>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.<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the provider did not ensure the ramps installed at 2 exits from the home were equipped with handrails. Resident 1 and Resident 2 utilized a cane for mobility. Resident 3 utilized a walker for mobility.<br><br>Findings include:<br><br>This facility was issued an ambulatory license on 07/23/2020 to serve up to 3 residents within the following client groups: developmentally disabled, correctional clients, alcohol/drug dependent, | M 262 | | |

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| M 262 | Continued From page 7 | M 262 | | |

traumatic brain injury and emotionally disturbed/mental illness.

On 04/02/2026, Surveyor completed a review of the Department facility folder and identified the following:

-On 08/03/2022, the Department granted a license amendment to increase capacity and the addition of client groups for this facility. The maximum number of residents who may live in this facility is 4. The client group including: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and/or dually diagnosed, alcohol/drug dependent, correctional clients, traumatic brain injury, developmentally disabled, pregnant women/counseling and terminally ill.

On 04/02/2026 through 04/03/2026, Surveyor reviewed resident records and identified the following:

Resident 1
-Resident 1 was admitted to the provider's home on 11/02/2022.

-Resident 1's Individual Service Plan (ISP), dated 05/08/2025, documented the following: "Resident 1 is semi-ambulatory. Resident 1 walks with a cane to stabilize his/her unsteady gate."

Resident 2
-Resident 2 was admitted to the provider's home on 06/25/2023.

-Resident 2's Health Certificate, dated 07/05/2025, completed by Resident 2's physician, documented the following: "Patient ambulates with prescribed assistive device and assistance

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| M 262 | Continued From page 8 | M 262 | | |

as needed: Yes. If yes, name assistive device/assistance needed: Cane."

Resident 3
-Resident 3 was admitted to the provider's home on 12/04/2024.

-Resident 3's ISP, dated 12/04/2024, documented the following: "Resident 3 uses a cane or walker for mobility. Staff will provide assistance as needed with mobility, including the use of a walker and will help prevent falls by ensuring the environment is clear of hazards."

On 04/02/2026, at approximately 3:04 PM, Surveyor interviewed Caregiver E. Caregiver E reported Resident 1 and Resident 2 utilized a cane for mobility and Resident 3 utilized a walker for mobility.

On 04/02/2026, at approximately 5:02 PM, Surveyor conducted a tour of the facility with Licensee A and observed the following:

-The front exit ramp did not have a handrail on left side of the ramp.

-The rear exit ramp did not have a handrail on left side of the ramp.

On 04/02/2026, at approximately 5:02 PM, Surveyor interviewed Licensee A. Licensee A confirmed the front and rear ramps did not have a handrail on left side. Licensee A confirmed Resident 1 and Resident 2 utilized a cane and Resident 3 utilized a walker for mobility. Licensee A reported s/he will get handrails added to the left side of front and rear exit ramps.

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| M 274 | Continued From page 9 | M 274 | | |
| M 274 | 88.05(2)(d) BEDROOM ON FIRST FLOOR<br><br>Any resident who is unable to easily negotiate stairs without assistance shall have his or her bedroom, toilet and bathing facilities and all common living areas on the first floor.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident (Resident 2), who utilized a cane for mobility had a bedroom, toilet and bathing facilities and all common living areas on the first floor. The common areas are located on the first floor of the facility and Resident 2's bedroom is on the second floor of the facility.<br><br>Resident 2 who required a cane to ambulate, had a bedroom on the second floor of the single family home.<br><br>Findings include:<br><br>This facility was issued an ambulatory license on 07/23/2020 to serve up to 3 residents within the following client groups: developmentally disabled, correctional clients, alcohol/drug dependent, traumatic brain injury and emotionally disturbed/mental illness.<br><br>On 04/02/2026, Surveyor completed a review of the Department facility folder and identified the following:<br><br>-On 08/03/2022, the Department granted a license amendment to increase capacity and the addition of client groups for this facility. The maximum number of residents who may live in this facility is 4. The client group including: | M 274 | | |

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| M 274 | Continued From page 10 | M 274 | | |

emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and/or dually diagnosed, alcohol/drug dependent, correctional clients, traumatic brain injury, developmentally disabled, pregnant women/counseling and terminally ill.

On 04/02/2026, at approximately 5:02 PM, while conducting a tour of the facility with Licensee A, Surveyor observed the following:

-There were two bedrooms (Resident 1's and Resident 3's) on the first floor of the home.

-There was one bedroom (Resident 2's) on the upper level of the home.

-Resident 2 in his/her bedroom on the upper level of the home.

-The stairwell leading to the upper level of the home contained approximately thirteen to fourteen steps to Resident 2's bedroom.

On 04/03/2026, Surveyor reviewed Resident 2's record and identified the following:

-Resident 2 was admitted to the provider's home on 06/25/2023.

-Resident 2's Health Certificate, dated 07/05/2025, completed by Resident 2's physician, documented the following: "Patient ambulates with prescribed assistive device and assistance as needed: Yes. If yes, name assistive device/assistance needed: Cane."

On 04/02/2026, at approximately 5:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 2 required a cane to

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| M 274 | Continued From page 11<br>ambulate and had a bedroom on the upper level of the home. Licensee A stated s/he was not aware of the requirement to provide a first-floor bedroom for a resident who had utilized a cane for mobility. | M 274 | | |
| M 276 | 88.05(3)(a) Homelike Environment<br><br>An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure a clean, well-maintained and homelike environment. This had the potential to affect 3 of 3 residents residing in the home. The walls, doors, and doorframes showed signs of scraping throughout the home. The bathroom was in need of floor and door repairs and cleaning.<br><br>Findings include:<br><br>On 04/02/2026 through 04/03/2026, Surveyor toured the home with Licensee A and observed the following:<br><br>-Door and door frames throughout home showed signs of scratches.<br><br>-Walls throughout home contained a white chalk | M 276 | | |

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| M 276 | Continued From page 12<br>substance.<br><br>-Walls throughout home contained numerous dark scuff and scratch marks.<br><br>-Walls throughout home showed signs of scraping.<br><br>-Wall trimming was darkened in areas and showed signs of scraping throughout home.<br><br>-Door near basement stairwell was missing transition strip.<br><br>-Bathroom flooring showed signs of cracking.<br><br>-Bathroom walls showed signs of scraping.<br><br>-Bathroom walls had a white chalk substance.<br><br>-Bathroom door had discoloration.<br><br>-There was caked up lint behind dryer in basement.<br><br>On 04/03/2026, at approximately 4:55 PM, Surveyor interviewed Licensee A. Licensee A confirmed the above-mentioned home environment issues throughout the home. Licensee A reported s/he would ensure the homelike environment issues were addressed. | M 276 | | |
| M 332 | 88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS<br><br>Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire | M 332 | | |

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| M 332 | Continued From page 13<br>extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure 4 of 4 fire extinguishers were inspected annually by an authorized dealer and had an attached tag showing the date of inspection. The fire extinguishers, located in the living room, upper level of home, in the kitchen and in the basement did not have an attached tag showing the date of the last inspection. The provider also did not ensure 1 of 4 fire extinguishers was mounted. The fire extinguisher located in the living room was sitting on top of the file cabinet.<br><br>Findings include:<br><br>This facility is licensed to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible | M 332 | | |

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| M 332 | Continued From page 14<br>dementia/Alzheimer's, alcohol/drug dependent, correctional clients, traumatic brain injury, developmentally disabled, pregnant women/counseling and terminally ill.<br><br>On 04/02/2026 through 04/03/2026, Surveyor toured the home with Licensee A and observed the following:<br><br>-Fire extinguishers, located in the living room, upper level of home, in the kitchen and in the basement did not have an attached tag showing the date of the last inspection.<br><br>-Fire extinguisher located in the living room was sitting on top of the file cabinet. Fire extinguisher was not mounted.<br><br>On 04/03/2026, at approximately 4:55 PM, Surveyor interviewed Licensee A. Licensee A confirmed the above-mentioned issues. Licensee A reported s/he was not aware of these requirements. | M 332 | | |
| M 346 | 88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION<br><br>Each resident shall be evaluated annually for evacuation time, using 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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the | M 346 | | |

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| M 346 | Continued From page 15<br>provider did not ensure 2 of 3 residents (Resident 2 and Resident 3) reviewed were evaluated annually for evacuation time, using the Department's form. Resident 2 had not been evaluated for evacuation for calendar years 2024 and 2025. Resident 3 had not been evaluated for evacuation for calendar year 2025.<br><br>Findings include:<br><br>This facility was issued an ambulatory license on 07/23/2020 to serve up to 3 residents within the following client groups: developmentally disabled, correctional clients, alcohol/drug dependent, traumatic brain injury and emotionally disturbed/mental illness.<br><br>On 04/02/2026, Surveyor completed a review of the Department facility folder and identified the following:<br><br>-On 08/03/2022, the Department granted a license amendment to increase capacity and the addition of client groups for this facility. The maximum number of residents who may live in this facility is 4. The client group including: emotionally disturbed/mental illness, physically disabled, advanced aged, irreversible dementia/Alzheimer's and/or dually diagnosed, alcohol/drug dependent, correctional clients, traumatic brain injury, developmentally disabled, pregnant women/counseling and terminally ill.<br><br>On 04/02/2026 through 04/03/2026, Surveyor reviewed resident records and identified the following:<br><br>Resident 2<br>-Resident 2 was admitted to the provider's home on 06/25/2023. | M 346 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| M 346 | Continued From page 16<br><br>-Resident 2's record did not contain evidence of an evacuation assessment for calendar years 2024 and 2025 using the Department's form.<br><br>Resident 3<br>-Resident 3 was admitted to the provider's home on 12/04/2024.<br><br>-Resident 3's record did not contain evidence of an evacuation assessment for calendar year 2025 using the Department's form.<br><br>On 04/03/2026, at approximately 4:55 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 2's and Resident 3's records did not contain evidence of the above-mentioned evacuation assessments. Licensee A reported moving forward s/he will ensure residents were evaluated annually for evacuation time, using the Department's form. | M 346 | | |
| M 380 | 88.06(2)(a) ADMISSION-HEALTH EXAM<br><br>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 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. | M 380 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| M 380 | Continued From page 17<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 3 residents (Resident 3) was screened for communicable disease within 90 days prior to admission to the home or within 7 days after admission.<br><br>Findings include:<br><br>On 04/02/2026, Surveyor reviewed Resident 3's record and identified the following:<br><br>-Resident 3 was admitted to the provider's home on 12/04/2026.<br><br>-Resident 3's record did not include evidence of a communicable disease screening.<br><br>On 04/02/2026, at approximately 6:28 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 3's record did not include evidence Resident 3 was screened for communicable disease. Licensee A reported s/he was not aware of this requirement. | M 380 | | |
| M 384 | 88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE<br><br>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 | M 384 | | |

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| M 384 | Continued From page 18<br>persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any.<br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 2) reviewed had a service agreement completed signed and dated by the licensee, resident, or resident's guardian or designated representative prior to admission.<br><br>Findings include:<br><br>On 04/03/2026, Surveyor reviewed resident records and identified the following:<br><br>Resident 1<br>-Resident 1 was admitted to the provider's home on 11/02/2022.<br>-Resident 1 had an activated healthcare power of attorney.<br>-Resident 1's record did not contain evidence of a service agreement.<br><br>Resident 2<br>-Resident 2 was admitted to the provider's home on 06/25/2023.<br>-Resident 2 had a legal guardian.<br>-Resident 2's record did not contain evidence of a service agreement.<br><br>On 04/03/2026, Surveyor requested Resident 1's and Resident 2's service agreement from Licensee A.<br><br>On 04/03/2026, at approximately 4:55 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1's and Resident 2's records did not contain evidence of a service agreement. | M 384 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| M 384 | Continued From page 19<br>Licensee A reported s/he was unable to locate a service agreement for Resident 1 and Resident 2. | M 384 | | |
| M 386 | 88.06(2)(c) SERVICE AGREEMENT REQUIREMENTS<br><br>A service agreement shall specify all of the following:<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 3) reviewed service agreement specified the following: the names of the parties to the agreement, the services that will be provided and a description of each, charges for room and board and services, the frequency, amount, source and method of payment, the policy on refunds, how personal funds will be handled, conditions for transfer or discharge and the assistance a licensee will provide in relocating a resident and a statement indicating that the resident rights and grievance procedures have been explained and copies provided to the resident and the resident's guardian or designated representative, if any.<br><br>Findings include:<br><br>On 04/02/2026, Surveyor reviewed Resident 3's record and identified the following:<br><br>-Resident 3 was admitted to the provider's home on 12/04/2024. | M 386 | | |

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| M 386 | Continued From page 20<br><br>-Resident 3's service agreement did not specify the following: the names of the parties to the agreement, the services that will be provided and a description of each, charges for room and board and services, the frequency, amount, source and method of payment, the policy on refunds, how personal funds will be handled, conditions for transfer or discharge and the assistance a licensee will provide in relocating a resident and a statement indicating that the resident rights and grievance procedures have been explained and copies provided to the resident and the resident's guardian or designated representative, if any.<br><br>On 04/02/2026, at approximately 6:28 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 3's service agreement did not specify the following: the names of the parties to the agreement, the services that will be provided and a description of each, charges for room and board and services, the frequency, amount, source and method of payment the policy on refunds, how personal funds will be handled, conditions for transfer or discharge ad the assistance a licensee will provide in relocating a resident and a statement indicating that the resident rights and grievance procedures have been explained and copies provided to the resident and the resident's guardian or designated representative, if any. Licensee A stated moving forward s/he will ensure residents service agreements includes this information. | M 386 | | |
| M 404 | 88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT<br><br>The licensee shall ensure that a written assessment and individual | M 404 | | |

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| M 404 | Continued From page 21<br>service plan is completed and developed for each resident within 30 days after placement.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 3 residents (Resident 1, Resident 2 and Resident 3) reviewed had a written assessment and individual service plan (ISP) completed and developed within 30 days after admission. Resident 1 and Resident 3 did not have a written assessment completed and developed within 30 days after admission. Resident 2 did not have a written assessment and ISP completed and developed within 30 days after admission.<br><br>Findings include:<br><br>On 04/02/2026 through 04/03/2026, Surveyor reviewed resident records and identified the following:<br><br>Resident 1<br>-Resident 1 was admitted to the provider's home on 11/02/2022.<br><br>-Resident 1's record did not contain a written assessment completed within 30 days after admission.<br><br>Resident 2<br>-Resident 2 was admitted to the provider's home on 06/25/2023.<br><br>-Resident 2's record did not contain a written assessment and ISP completed and developed | M 404 | | |

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| M 404 | Continued From page 22<br>within 30 days after admission.<br><br>Resident 3<br>-Resident 3 was admitted to the provider's home on 12/04/2024.<br><br>-Resident 3's record did not contain a written assessment completed within 30 days after admission.<br><br>On 04/03/2026, at approximately 4:55 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1's and Resident 3's records did not contain a written assessment completed within 30 days after admission. Licensee A confirmed Resident 2's record did not contain a written assessment and ISP completed and developed within 30 days after admission. Licensee A reported s/he was responsible for the assessments and creating ISPs. Licensee A reported s/he did not realize the above-mentioned issues until Surveyor requested documentation. Licensee A reported moving forward s/he would ensure all residents have a written assessment and ISP within 30 days after admission. | M 404 | | |
| M 420 | 88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT<br><br>A statement of agreement with the plan, dated and signed by all persons involved in developing the plan.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident | M 420 | | |

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| M 420 | Continued From page 23 | M 420 | | |

1 and Resident 3) reviewed individual service plans (ISP) included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 1's and Resident 3's ISPs did not include a signed statement of agreement with all parties involved.

Findings include:

On 04/02/2026 through 04/03/2026, Surveyor reviewed resident records and identified the following:

Resident 1
- Resident 1 was admitted to the provider's home on 11/02/2022.
- Resident 1 had an activated healthcare power of attorney (POA).
- The consumer roster identified Resident 1 had a managed care organization (MCO) case management team.
- Resident 1's ISP dated 05/08/2025 did not contain his/her POA or MCO case management team signatures.

Resident 3
- Resident 3 was admitted to the provider's home on 12/04/2024.
- Resident 3 had a legal guardian.
- The consumer roster identified Resident 3 had an MCO case management team.
- Resident 3's ISP dated 12/04/2024 did not contain his/her guardian or MCO case management team signatures.

On 04/03/2026, at approximately 10:22 AM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1's and Resident 3's ISPs were not signed by the above-mentioned parties. Licensee A reported s/he was not aware the

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| M 420 | Continued From page 24<br>MCO, POA or guardian were required to sign the residents' ISPs. | M 420 | | |
| M 424 | 88.06(3)(f) REVIEW OF ISP<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 3 residents (Resident 1, Resident 2, and Resident 3) 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.<br><br>Findings include: | M 424 | | |

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| M 424 | Continued From page 25<br>On 04/02/2026 through 04/03/2026, Surveyor reviewed resident records and identified the following:<br><br>Resident 1<br>-Resident 1 was admitted to the provider's home on 11/02/2022.<br>-Resident 1 had an activated healthcare power of attorney (POA).<br>-There was no evidence Resident 1's ISP was reviewed and updated after 05/08/2025. At minimum, Resident 1's ISP should have been reviewed and updated in November 2025.<br><br>Resident 2<br>-Resident 2 was admitted to the provider's home on 06/25/2023.<br>-Resident 2 had a legal guardian.<br>-Resident 2's record did not contain an ISP. Resident 2 was due for an ISP by 07/25/2023, 01/2024, 07/2024, 01/2025, 07/2025 and 01/2026.<br><br>Resident 3<br>-Resident 3 was admitted to the provider's home on 12/04/2024.<br>-Resident 3 had a legal guardian.<br>-There was no evidence Resident 3's ISP was reviewed and updated after 12/04/2024. At minimum, Resident 3's ISP should have been reviewed and updated in June 2025 and December 2025.<br><br>On 04/03/2026 at approximately 4:55 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 residents ISPs should have been reviewed at least once every 6 months to determine continued appropriateness of the plan and to | M 424 | | |

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| M 424 | Continued From page 26<br>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 464 | 88.07(3)(d) MEDICATION- WRITTEN ORDER<br><br>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.<br><br>This Rule is not met as evidenced by:<br>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 3 of 3 residents (Resident 1, Resident 2 and Resident 3) reviewed who required staff to administer his/her medications. Resident 1, Resident 2 and Resident 3 did not have a written order permitting the provider staff to administer medications.<br><br>Findings include:<br><br>On 04/02/2026 through 04/03/2026, Surveyor reviewed resident records and identified the following: | M 464 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017931 | A. BUILDING: _____ B. WING _____ | 04/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RELENTLESS CARE LLC | 4303 N 66TH ST MILWAUKEE, WI 53216 |

| (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 27<br><br>Resident 1<br>-Resident 1 was admitted to the provider's home on 11/02/2022.<br><br>-Resident 1 did not have an order specifying who by name or position could administer his/her medication.<br><br>Resident 2<br>-Resident 2 was admitted to the provider's home on 06/25/2023.<br><br>-Resident 2 did not have an order specifying who by name or position could administer his/her medication.<br><br>Resident 3<br>-Resident 3 was admitted to the provider's home on 12/04/2024.<br><br>-Resident 3 did not have an order specifying who by name or position could administer his/her medication.<br><br>On 04/03/2026, at approximately 4:55 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1, Resident 2 and Resident 3 required staff to administer their medication. Licensee A confirmed Resident 1's, Resident 2's and Resident 3's records did not contain evidence of a written order permitting the provider staff to administer medications from the physician for Resident 1, Resident 2 and Resident 3. Licensee A reported s/he was not aware of this requirement until Surveyor requested documentation. | M 464 | | |
| Z 012 | 50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS | Z 012 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017931 | A. BUILDING: _____ B. WING _____ | 04/07/2026 |

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|---|---|---|---|---|
| Z 012 | Continued From page 28<br><br>If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1.<br><br>The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure 1 of 3 staff (Manager B) out of state background check, for staff living out of state within the last three years, was completed.<br><br>Findings include: | Z 012 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017931 | A. BUILDING: _____ B. WING _____ | 04/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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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 |
|---|---|---|---|---|
| Z 012 | Continued From page 29<br><br>On 04/03/2026, Surveyor reviewed Manager B's record and identified the following:<br><br>-Manager B was hired on 02/02/2022.<br><br>-Manager B's background information disclosure form (BID), dated 05/10/2025, indicated Manager B lived out of state within the last 3 years. Surveyor did not locate any evidence of an out-of-state background check in Manager B's record.<br><br>On 04/03/2026, at approximately 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported Manager B lived in Indiana in 2025. Licensee A confirmed the code requirement. Licensee A reported s/he was unsure how to conduct the out of state background check for Manager B. | Z 012 | | |