

Wisconsin Department of Health Services

|                                                       |                                                                                                                                                                           |                                                                                           |                                                                                                                          |                                                        |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0016426</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/22/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEMMA CARE</b> |                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6918 N 40TH PLACE<br/>MILWAUKEE, WI 53209</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                              | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| M 000                                                 | <p>INITIAL COMMENTS</p> <p>On 07/22/2026, Surveyor conducted an abbreviated survey at Gemma Care in Milwaukee.<br/>No deficiencies were identified.</p> <p>Census: 04</p> | M 000                                                                                     |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE