STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018775	A. BUILDING: _____ B. WING _____	R 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDLE GROUP LLC	**3947 N 24TH ST MILWAUKEE, WI 53206**

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{M 000}	INITIAL COMMENTS On 02/11/2026, Surveyor completed a verification visit at Randle Group LLC. As result, 5 of the previous 9 deficiencies were corrected. Four of the previous deficiencies were re-cited with 3 new deficiencies; therefore, 7 total deficiencies identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{M 000}		
M 234	88.04(2)(g)2 COMMUNICABLE DISEASE The licensee shall ensure that no one who has a communicable disease reportable under ch. HSS 145 may work in a position in the adult family home where the disease would present a significant risk to the health or safety of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each service provider was screened for communicable diseases by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service for 2 of 2 caregivers (Caregiver E and Caregiver F) reviewed. Findings include: On 02/11/2026, at 10:30 AM, Surveyor reviewed staff records and identified the following: Caregiver E was hired on 09/25/2025. Caregiver E's record contained a communicable disease	M 234		

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

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M 234	Continued From page 1 screening questionnaire dated 09/15/2025. The screening was not reviewed or signed by a physician, registered nurse (RN), or a physician's assistant (PA). Caregiver F was hired on 08/19/2025. Caregiver F's record contained a communicable disease screening questionnaire that was undated and incomplete. The screening was not reviewed or signed by a physician, RN, or a PA. On 02/11/2026 at approximately 11:00 AM, Surveyor interviewed Director C and House Manager D. Director C confirmed the code requirement. Director C reported s/he was unaware Caregiver E and Caregiver F's communicable disease screenings were not reviewed or signed by a physician, RN, or a PA. Director C reported s/he would ensure staff members communicable disease screenings were read by the appropriate medical professional for future employees.	M 234		
{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 well-maintained and home-like	{M 276}		

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{M 276}	Continued From page 2 environment for 4 of 4 of 4 residents in the home. The only bathroom in the home was not maintained and needed cleaning. This is a repeat deficiency. See Statement of Deficiency URR811, dated 08/13/2024. Findings include: On 02/11/2026, at approximately 9:30 AM, Surveyor toured the facility. During the tour, Surveyor observed the following: Bathroom -there was no toilet paper roll holder, it was missing from the wall and there were screws left in the wall -the vent by the toilet in the bathroom had a gray fluffy substance on face of the entire vent (consistent with dust) -the trim around the bathroom floor was covered in a gray fluff substance (consistent with dust) -there was a black substance (consistent with mold) on the bottom of the shower and tile of the floor - The drywall was dented in and cracked on the west wall of the bathroom - The ceiling exhaust vent was covered in a gray fluffy substance (consistent with dust) - Floor tiles in the bathroom were cracked and lifted near the shower On 02/11/2026 at approximately 11:00 AM, Surveyor interviewed Director C and House Manager D. Director C reported "some" repairs were completed after the prior survey. Director C reported s/he would ensure the bathroom repairs were completed.	{M 276}		

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M 332	Continued From page 3	M 332		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire 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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 fire extinguishers were inspected annually by an authorized dealer. The fire extinguishers were last inspected in July of 2024. Findings include: On 02/11/2026, at 9:30 AM, Surveyor toured the home. Surveyor observed 1 fire extinguisher in the kitchen. The fire extinguisher was last inspected July of 2024.	M 332		

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M 332	Continued From page 4 On 02/11/2026 at approximately 11:00 AM, Surveyor interviewed Director C and House Manager D. House Manager D reported s/he was not aware of the code requirement. House Manager D reported s/he was unaware the last inspection was completed in 2024.	M 332		
{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 complete the resident evacuation assessment within 3 days of admission for 1 of 1 resident (Resident 2). Resident 2's evacuation assessment was completed 9 days after admission. This is a repeat deficiency. See Statement of Deficiency URR811, dated 08/13/2024. Findings include: On 02/11/2026, at 10:30 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/25/2025. Resident 2's record contained an evacuation assessment dated 03/06/2026, 9 days	{M 344}		

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{M 344}	Continued From page 5 after Resident 2's admission. On 02/11/2026 at approximately 11:00 AM, Surveyor interviewed Director C and House Manager D. House Manager D was unaware of the code requirement. House Manager D reported s/he would ensure evacuation assessments are completed within 3 days of admission for new residents.	{M 344}		
{M 406}	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure 1 of 1 (Resident 2) resident individual service plans (ISPs) were developed, signed, and dated by all persons involved in developing the plan. Resident 2's ISP was not signed by Resident 2's case manager, or the Licensee/Administrator. This is a repeat deficiency. See Statement of Deficiency URR811, dated 08/13/2024. Findings include:	{M 406}		

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{M 406}	Continued From page 6 On 02/11/2026, at 10:30 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/25/2025. Resident 2's file contained an ISP dated 06/18/2025. Resident 2's file identified s/he had a managed care organization (MCO). Resident 2's ISP was not signed by Resident 2's MCO or the Licensee/Administrator. On 02/11/2026 at approximately 11:00 AM, Surveyor interviewed Director C and House Manager D. House Manager D reported s/he was unaware of the code requirement. Director C and House Manager D reported they were both responsible for updating ISPs. House Manager D reported s/he would ensure all parties involved would sign future ISP updates.	{M 406}		
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.	M 424		

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M 424	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure 1 of 1 (Resident 2) resident individual service plans (ISPs) were reviewed at least once every 6 months. Resident 2's ISP was due to be reviewed in 12/2025. Findings include: On 02/11/2026, at 10:30 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/25/2025. Resident 2's file contained an ISP dated 06/18/2025. Resident 2's ISP was due to be reviewed 12/2025. Surveyors did not review evidence of an updated ISP in Resident 2's file. On 02/11/2026 at approximately 11:00 AM, Surveyor interviewed Director C and House Manager D. Director C reported s/he was aware of the code requirement. Director C and House Manager D reported they were both responsible for updating ISPs. Director C confirmed Resident 2's ISP was due to be reviewed 12/2025. House Manager D reported s/he would ensure Resident 2's ISP was updated.	M 424		
{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	{M 570}		

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{M 570}	Continued From page 8 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 water temperatures were kept at a safe temperature for 1 of 1 bathroom. The hot water temperature in the resident bathroom was 161.2° Fahrenheit (F). This is a repeat deficiency. See Statement of Deficiency URR811, dated 08/13/2024. Findings include: The facility was licensed as an ambulatory adult family home (AFH), serving up to 4 residents in client groups emotionally disturbed/mental illness, traumatic brain injury/mental illness, physically disabled, terminally ill, advanced age, and irreversible dementia/Alzheimer's. On 02/11/2026, at 09:35 AM, Surveyor tested the water temperature in bathroom 1's sink faucet. The water temperature was 161.2° F. "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	{M 570}		

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{M 570}	Continued From page 9 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 02/11/2026 at approximately 11:00 AM, Surveyor interviewed Director C and House Manager D. Director C reported s/he was unaware of the water temperature limit. Director C reported s/he would ensure the water temperature was turned down and checked by staff members monthly.	{M 570}		