STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 03/18/2026 with information gathered through 03/20/2026, Surveyor conducted a standard survey, at 5 Star Adult Care Services LLC, an Adult Family Home (AFH) in Milwaukee, WI. Sixteen deficiencies identified. Census: 4	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,	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
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees' (Caregiver B, Caregiver C and Caregiver D) reviewed had a background check. Caregiver B, Caregiver C and Caregiver D did not have a background check. At a minimum, a complete caregiver background check completed for a caregiver consists of the following three documents: - A completed DHS form F-82064, Background Information Disclosure (BID). - A response from the Department of Justice (DOJ), either - A "no record found" response or - A criminal record transcript. - A Governmental Findings Report (previously "IBIS letter") from DHS that reports the person' s status, including administrative finding or licensing restrictions. Findings include: On 03/19/2026, at approximately 12:31 PM, Surveyor requested Caregiver B's record from Licensee A. Surveyor informed Licensee A that Surveyor needed Caregiver B's record by 5:00 PM.	M 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 On 03/19/2026, at approximately 7:44 PM, Surveyor received Caregiver B's record via email from Licensee A and identified the following: -Caregiver B was hired on 07/03/2025. -Caregiver B's record did not include a BID. -Caregiver B's record did not contain evidence of a DOJ. -Caregiver B's record did not contain a Governmental Findings Report. On 03/19/2026, at approximately 12:31 PM, Surveyor requested Caregiver C's record from Licensee A. Surveyor informed Licensee A that Surveyor needed Caregiver C's record by 5:00 PM. On 03/19/2026, at approximately 7:51 PM, Surveyor received Caregiver C's record via email from Licensee A and identified the following: -Caregiver C was hired on 08/14/2025. -Caregiver C's record included an incomplete BID (Page 2 missing). -Caregiver C's record did not contain evidence of a DOJ. -Caregiver C's record did contain a Governmental Findings Report, dated 08/12/2025. On 03/19/2026, at approximately 12:31 PM, Surveyor requested Caregiver D's record from Licensee A. Surveyor informed Licensee A that Surveyor needed Caregiver D's record by 5:00	M 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 3 PM. On 03/19/2026, at approximately 7:55 PM, Surveyor received Caregiver D's record via email from Licensee A and identified the following: -Caregiver D was hired on 01/21/2026. -Caregiver D's record did not include a BID. -Caregiver D's record did not contain evidence of a DOJ. -Caregiver D's record did not contain a Governmental Findings Report. On 03/20/2026, at approximately 1:25 PM, Surveyor interviewed Licensee A. Licensee A confirmed s/he sent Caregiver B's, Caregiver C's and Caregiver D's records to Surveyor via email and all pieces of the background checks should have been included.	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.	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 4	M 232		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 3 of 3 service providers (Caregiver B, Caregiver C and Caregiver D) were screened for illness detrimental to residents, including tuberculosis (TB). Caregiver B's, Caregiver C's and Caregiver D's records did not contain documentation of being screened for illness detrimental to residents or TB test results.

Findings include:

On 03/18/2026, Surveyor reviewed the staff roster and identified the following:

-Caregiver B was hired on 07/03/2025.

-Caregiver C was hired on 08/14/2025.

-Caregiver D was hired on 01/21/2026.

On 03/19/2026, at approximately 12:31 PM, Surveyor requested Caregiver B's, Caregiver C's and Caregiver D's health screening documentation from Licensee A.

On 03/19/2026, at approximately 12:31 PM, Surveyor interviewed Licensee A. Licensee A reported s/he would send documentation via-email to Surveyor. Surveyor informed Licensee A that Surveyor would need this documentation by 5:00 PM.

As of 03/20/2026 at 5:00 PM, Surveyor did not receive evidence of Caregiver B's, Caregiver C's and Caregiver D's health screening documentation (screened for illness detrimental to resident or TB skin test results).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees (Caregiver B and Caregiver D) reviewed received training in universal 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. Caregiver B and Caregiver D did not receive training in universal precautions at the time of initial assignment of tasks where occupational exposure may have taken place. 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). Findings include: On 03/18/2026, Surveyor reviewed the staff roster and identified the following:	M 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 235	Continued From page 6 -Caregiver B was hired on 07/03/2025. -Caregiver D was hired on 01/21/2026. On 03/19/2026, at approximately 12:31 PM, Surveyor requested Caregiver B's and Caregiver D's training documentation from Licensee A. On 03/19/2026, at approximately 12:31 PM, Surveyor interviewed Licensee A. Licensee A reported caregivers worked directly with residents to meet all their needs including incontinence cares. Licensee A reported s/he would send documentation via-email to Surveyor. Surveyor informed Licensee A that Surveyor would need this documentation by 5:00 PM. As of 03/20/2026 at 5:00 PM, Surveyor did not receive evidence of Caregiver B's and Caregiver D's training documentation (universal precautions training prior to providing care to residents).	M 235		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training 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:	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 7 Based on record review and interview, the provider did not ensure 2 of 2 caregivers (Caregiver B and Caregiver C) received 15 hours of training related to health, safety and welfare of residents, resident rights and treatment, fire safety and first aid prior to or within 6 months after starting to provide care. Findings include: On 03/18/2026, Surveyor reviewed the staff roster and identified the following: -Caregiver B was hired on 07/03/2025. -Caregiver C was hired on 08/14/2025. On 03/19/2026, at approximately 12:31 PM, Surveyor requested Caregiver B's and Caregiver C's initial training documentation from Licensee A. On 03/19/2026, at approximately 12:31 PM, Surveyor interviewed Licensee A. Licensee A reported s/he would send documentation via-email to Surveyor. Surveyor informed Licensee A that Surveyor would need this documentation by 5:00 PM. As of 03/20/2026 at 5:00 PM, Surveyor did not receive any training documentation for Caregiver B and Caregiver C.	M 244		
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.	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 276	Continued From page 8	M 276		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure a clean, well-maintained and homelike environment. The home required cleaning and repairs. This had the potential to affect 4 of 4 residents residing in the home.

Findings include:

On 03/18/2026, at approximately 9:48 AM, Surveyor toured the home with Licensee A and observed the following:

-Kitchen refrigerator and freezer door gaskets contained food debris.

-Brown and yellowish substance on freezer door and on top of kitchen refrigerator.

-Refrigerator venting system displayed the appearance of dirt build-up.

-Living room flooring had discoloration throughout.

-Living room windowsill was dirty and showed significant scratches.

-Hallway (near bathroom) flooring had discoloration throughout.

-Door and door frames throughout home showed significant scratches.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 276	Continued From page 9 -Walls throughout home contained numerous dark scuff and scratch marks. -Walls throughout home showed significant signs of scraping. -Front entrance door transition strip contained dirt build-up and discoloration. -Rear door transition strip contained dirt build-up and discoloration. -Transition strip between the hallway and kitchen had discoloration. -Wall vents were rusted and caked with a substance consistent to dust throughout home. -Wall trimming was dirty and showed significant signs of scraping throughout home. -Bathroom flooring showed significant signs of cracking. -Bathroom had missing flooring tiles. -Bathroom walls showed significant signs of scraping. -Bathroom walls had a white chalk substance. -Bathroom floor vent was rusted. -Furnace showed signs of leaking. -Basement floor contained water and brown residue near furnace. -There was caked up lint behind dryer in	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 276	Continued From page 10 basement. On 03/18/2026, at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A stated s/he was aware of the home environment issues throughout the home. Licensee A reported s/he would ensure the homelike environment issues were addressed.	M 276		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company. This Rule is not met as evidenced by: Based on record review and interview the facility did not ensure the gas furnace was inspected and serviced every 3 years by a heating contractor or local utility company for 1 of 1 furnace. Findings include: The facility was licensed on 12/05/2016 as a non-ambulatory home, which may serve up to 4 individuals with diagnoses including irreversible dementia/Alzheimer's, developmentally disabled, physically disabled, advanced aged and emotionally disturbed/mental illness. On 03/18/2026, Surveyor requested to review facility's most recent furnace inspection from Licensee A. There was no evidence of a furnace inspection for review. On 03/19/2026, at approximately 2:30 PM, Surveyor received an email from Licensee A reporting the following: "Hello I am waiting on the	M 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 290	Continued From page 11 homeowner to give me the information [sic] when the inspection was done due to them paying for it the company couldn't give me the invoice so I'm trying to see if they can send me a copy." As of 03/20/2026 at 5:00 PM, Surveyor did not receive evidence of the facility's most recent furnace inspection.	M 290		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in 1 of 7 required locations. There was no smoke detector at the door leading to enclosed stairwell to second floor. Findings include:	M 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 334	Continued From page 12 The facility was licensed on 12/05/2016 as a non-ambulatory home, which may serve up to 4 individuals with diagnoses including irreversible dementia/Alzheimer's, developmentally disabled, physically disabled, advanced aged and emotionally disturbed/mental illness. On 03/18/2026, at approximately 9:48 AM, Surveyor toured the home with Licensee A and observed the following: -The door leading to enclosed stairwell to second floor did not contain a smoke detector. On 03/18/2026, at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A confirmed there was no smoke detector at the door leading to enclosed stairwell to second floor. Licensee A reported s/he was not aware of this requirement.	M 334		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home had 2 exits which provided unobstructed access to the outside. One of 2 exits was obstructed by snow bank. Findings include:	M 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 338	Continued From page 13 The facility was licensed on 12/05/2016 as a non-ambulatory home, which may serve up to 4 individuals with diagnoses including irreversible dementia/Alzheimer's, developmentally disabled, physically disabled, advanced aged and emotionally disturbed/mental illness. On 03/18/2026, at approximately 9:48 AM, Surveyor toured the home with Licensee A and observed the following: -The back door ramped exit sloped access point was obstructed by snow bank. On 03/18/2026, at approximately 9:58 AM, Surveyor interviewed Licensee A. Licensee A acknowledged the back door ramped exit was obstructed by snow bank. Licensee A reported the snow removal person did not remove the snow appropriately.	M 338		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM 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
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 380	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents (Resident 3 and Resident 4) were screened for communicable disease within 90 days prior to admission to the home or within 7 days after admission. Findings include: On 03/18/2026, Surveyor reviewed resident records and identified the following: Resident 3 -Resident 3 was admitted to the provider's home on 06/19/2024. -Resident 3's record did not include evidence of a communicable disease screening. Resident 4 -Resident 4 was admitted to the provider's home on 01/18/2025. -Resident 4's record did not include evidence of a communicable disease screening. On 03/18/2026, at approximately 12:22 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 3's and Resident 4's records did not include evidence residents were screened for communicable disease.	M 380		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need.	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 412	Continued From page 15	M 412		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not have a description of services the licensee would provide to meet the assessed needs for 1 of 4 residents (Resident 4) reviewed. Resident 4's ISP did not identify what Resident 4's needs were for managing behaviors.

Findings include:

On 03/18/2026, Surveyor reviewed Resident 4's record and identified the following:

Resident 4
-Resident 4 was admitted to the provider's home on 01/18/2025 with diagnosis of autistic disorder.

-Resident 4's Care Plan (from the Managed Care Organization), dated 11/17/2025, documented the following: "Mental/Behavioral Health & Wellness - Person/agency providing assistance: [AFH] staff. [Resident 4] has a Behavior Support Plan (BSP)."

Resident 4's BSP (from the Managed Care Organization), dated 11/18/2025, documented the following: "Description of Challenging or Dangerous "Target" Behaviors: Elopement: [Resident 4] may leave the home without notifying staff [s/he] leaving nor where [s/he] plans to go. [Resident 4] gets lost easily and presents as vulnerable when alone in the community. Agitation: [Resident 4] may raise [his/her] voice, slam doors and/or use profanity.

Situations/Circumstances When Behaviors are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 412	Continued From page 16 Likely to Occur -When triggered by interactions with [his/her] mom. -When [his/her] routine changes suddenly. -When told no. Behavioral Signs and Signals Prior to Exhibiting Target Behaviors -[Resident 4] may go into a fetal position, ring [his/her] hands, and/or become shaky. How staff/Others Can Support and Encourage Appropriate Behavior -Take note of when [Resident 4] is and/or has spoken to [his/her] mom and be prepared to offer [him/her] one of [his/her] favorite things to do such as listening to music, watching a movie and/or TV and/or give [him/her] a soda. -Also be ready to talk things out with [Resident 4] regarding [his/her] mom and do so in as calm a manner as possible. -[Resident 4] doesn't do well with a change in routine so with as much advance notice as possible inform [him/her] of any changes to [his/her] schedule. -Have a conversation with [Resident 4] to try and identify as many activities as [s/he] likes and offer them to [him/her] routinely. -On hot summer days make sure to check with [Resident 4] to make sure [his/her] bedroom is at a comfortable temperature as being overheated can lead to agitation.	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 412	Continued From page 17 -Do your best to keep [Resident 4] in a line of sight and/or check oh [his/her] whereabouts in the home as [s/he] has a tendency to leave the home without notice. How Staff Should Respond When Target Behaviors Occur -When [Resident 4] has become agitated make sure to remain at least an arm's length distance from [him/her]. Speak to [him/her] in a calm tone of voice with a relaxed body language and offer to talk with [him/her] about what's upsetting [him/her]. -If [Resident 4] does not want to talk about what's agitating [him/her] ask [him/her] to select an activity to engage in. -If [Resident 4] does not want to select an activity offer [him/her] the opportunity to go to a spot in the home where [s/he] can calm down. -If [Resident 4] has eloped attempt to contact [him/her] on [his/her] cell phone and encourage [him/her] to return to the home. If [s/he] states [s/he] is lost then contact the police and ask them to search for [him/her] providing any last known whereabouts. -If [Resident 4] does not answer [his/her] cell phone leave a voice mail asking [him/her] to call back and return to the home. Then contact the police and ask for them to conduct a search of the area surrounding the home." -Resident 4's ISP, dated 07/16/2025, documented the following: "Attitude. Current Status: [Resident 4] has anger when [s/he] is upset but [s/he] is able to be redirected with	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 412	Continued From page 18 communication. Aggressive/Combative. Current Status: [Resident 4] has shown signs of aggression but has not harmed anyone. Frequency of service and service provided: Watch for change and redirect. Wandering. Current Status: No." Resident 4's ISP did not identify what Resident 4's needs were for managing behaviors. Resident 4's ISP did not include a description of service staff were to implement to manage behaviors. Resident 4's ISP did not identify how the staff should respond when target behaviors occurred. Resident 4's ISP did not identify Resident 4's elopement plans and procedure. On 03/20/2026, at approximately 1:25 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was responsible for the creation of ISPs. Licensee A confirmed Resident 4's ISPs did not reflect the above-mentioned information. Licensee A stated moving forward s/he would ensure residents ISPs provided detailed information.	M 412		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan.	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 420	Continued From page 19 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 residents (Resident 1, Resident 2, Resident 3 and Resident 4) individual service plans (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 1's, Resident 2's, Resident 3's and Resident 4's ISPs did not include a signed statement of agreement with all parties involved. Findings include: On 03/18/2026, Surveyor reviewed resident records and identified the following concerns: Resident 1 - Resident 1 was admitted to the provider's home on 12/21/2017. - Resident 1 had a legal guardian. - The consumer roster identified Resident 1 had a managed care organization (MCO) case management team. - Resident 1's ISP dated 09/01/2025 did not contain his/her guardian signature. - Resident 1's ISPs dated 01/15/2024, 08/07/2024, 02/01/2025 and 09/01/2025 did not contain MCO case management team signatures. Resident 2 - Resident 2 was admitted to the provider's home on 03/21/2019. - Resident 2 had a legal guardian. - The consumer roster identified Resident 2 had an MCO case management team. - Resident 2's ISPs dated 01/24/2024, 06/26/2024, 12/22/2024 and 06/15/2025 did not contain his/her guardian signature or MCO case management team signatures.	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 420	Continued From page 20 Resident 3 - Resident 3 was admitted to the provider's home on 06/19/2024. - Resident 3 had an activated healthcare power of attorney (POA). - The consumer roster identified Resident 3 had an MCO case management team. - Resident 3's ISP dated 01/28/2026 did not contain POA signature. - Resident 3's ISPs dated 06/19/2024, 12/01/2024, 07/22/2025 and 01/28/2026 did not contain MCO case management team signatures. Resident 4 - Resident 4 was admitted to the provider's home on 01/18/2025. - Resident 4 was his/her own person. - The consumer roster identified Resident 4 had an MCO case management team. - Resident 4's ISPs dated 01/18/2025 and 07/16/2025 did not contain MCO case management team signatures. On 03/20/2026, at approximately 1:25 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1's, Resident 2's, Resident 3's and Resident 4's ISPs were not signed by the above-mentioned parties. Licensee A reported s/he was not aware the MCO, POA or guardian were required to sign the residents' ISPs.	M 420		
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	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 424	Continued From page 21	M 424		

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.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 3 of 4 residents (Resident 1, Resident 2, and Resident 4) 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.

Findings include:

On 03/18/2026, Surveyor reviewed residents' records and identified the following:

-Resident 1 was admitted to the provider's home on 12/21/2017.
-Resident 1 had a legal guardian.
-There was no evidence Resident 1's ISP was reviewed and updated after 09/01/2025. At minimum, Resident 1's ISP should have been reviewed and updated by 03/01/2026.

-Resident 2 was admitted to the provider's home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 424	Continued From page 22 on 03/21/2019. -Resident 2 had a legal guardian. -There was no evidence Resident 2's ISP was reviewed and updated after 06/15/2025. At minimum, Resident 2's ISP should have been reviewed and updated in December 2025. -Resident 4 was admitted to the provider's home on 01/18/2025. -Resident 4 was his/her own person. -There was no evidence Resident 4's ISP was reviewed and updated after 07/16/2025. At minimum, Resident 4's ISP should have been reviewed and updated in January 2026. On 03/20/2026, at approximately 1:25 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 Resident 1's, Resident 2's and Resident 4's ISPs should have been reviewed at least once every 6 months to determine continued appropriateness of the plan and to update the plan as necessary.	M 424		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 458	Continued From page 23 This Rule is not met as evidenced by: Based on observation and interviews, the provider did not ensure all medication were securely stored. Resident 2's and Resident 3's medication were not securely stored in the home's refrigerator. Findings include: The facility is licensed as a non-ambulatory home, which may serve up to 4 individuals with diagnoses including irreversible dementia/Alzheimer's, developmentally disabled, physically disabled, advanced aged and emotionally disturbed/mental illness. On 03/18/2026, at approximately 9:09 AM, Surveyor observed a Sentry Safe black unlocked box on the second shelf of the home's common refrigerator. Inside of the Sentry Safe box Surveyorobserved the following residents' medication: Resident 2 - Zepbound 5 milligram (mg)/0.5 milliliter (ml) injection pen inject, beneath the skin 5 mg (0.5 ml) once a week (1 pen). Resident 3 - Latanoprost 0.005% 125 micrograms/2.5 ml eye drops instill 1 drop into each eye 1 time a day at bedtime (1 bottle). -Insulin Lispro KwikPen Injection 100 units per ml (U-100) inject under the skin per sliding scale insulin 4 times a day before meals and at bedtime (max 62 units/day) (6 pens).	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 458	Continued From page 24 - Basaglar KwikPen 100 unit/ml inject 8 units subcutaneously at bedtime prime 2 units before each dose (4 pens). On 03/18/2026, at approximately 9:09 AM, Surveyor interviewed Caregiver D. Caregiver D confirmed the Sentry Safe box was unlocked on the second shelf of refrigerator. Caregiver D reported the key was broken approximately a week ago. Caregiver D reported Licensee A was aware of the broken key. Caregiver D reported this was the second key broken by staff.	M 458		
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 specifying who by name or position could administer medications for 1 of 2 residents (Resident 3) reviewed who required staff to administer his/her medications. Resident 3 did not have a written order permitting the provider staff to administer medications.	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 25 Findings include: On 03/18/2026, Surveyor reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the facility on 06/19/2024. -Resident 3 did not have an order specifying who by name or position could administer his/her medication. On 03/18/2026, at approximately 12:22 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 3 required staff to administer his/her medication. Licensee A confirmed Resident 3's record did not contain evidence of a written order permitting the provider staff to administer medications from the physician for Resident 3.	M 464		
M 552	88.10(3)(c) Confidentiality Confidentiality. To have his or her records kept confidential as described in s. HSS 88.09(1)(b). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the confidentiality of residents' personal information for 1 of 1 resident (Resident 3). Specific details of Resident 3's administration of insulin was posted on the kitchen refrigerator and visible to other residents and visitors. Findings include: On 03/18/2026, at approximately 9:48 AM,	M 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 552	Continued From page 26 Surveyor toured the home with Licensee A and observed the following: -Note posted on the kitchen refrigerator stating the following: [Resident 3] should receive insulin 4 times daily follow [Medication Administration Record] mars.." On 03/18/2026, at approximately 9:48 AM, Surveyor interviewed Licensee A. Licensee A reported the note was posted on the kitchen refrigerator as a reminder to caregivers.	M 552		
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 by ensuring water temperatures were kept at a safe temperature for 1 of 1 resident bathroom. The hot water temperature in the resident bathroom was 139.6° Fahrenheit (F). Findings include:	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016260	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
5 STAR ADULT CARE SERVICES LLC	5442 N 20TH ST MILWAUKEE, WI 53209

(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 27 The facility is licensed as a non-ambulatory home, which may serve up to 4 individuals with diagnoses including irreversible dementia/Alzheimer's, developmentally disabled, physically disabled, advanced aged and emotionally disturbed/mental illness. On 03/18/2026, at approximately 10:45 AM, while touring the home with Licensee A Surveyor observed the following: -Surveyor tested the water temperature in the resident's bathroom sink faucet. The water temperature was 139.6° 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 forms scar tissue upon healing. These burns may lead to permanent disability." (Source: Publication DHS P-01942 - 08/2017). On 03/18/2026, at approximately 10:45 AM, Surveyor interviewed Licensee A regarding the temperature of the water. Licensee A confirmed that the water temperature in the resident's bathroom reached 139.6° F. Licensee A reported the water temperature is tested monthly. Licensee A reported s/he would have the water temperature adjusted.	M 570		