STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015434	A. BUILDING: _____ B. WING _____	R 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLAGG STREET MANOR II	**5650 N 87TH STREET MILWAUKEE, WI 53225**

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{M 000}	INITIAL COMMENTS On 04/16/2026, Surveyor conducted a verification visit and complaint investigation at Flagg Street Manor II. As a result, 1 previous cited deficiency was correct, 3 deficiencies were recited, and 2 new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 3	{M 000}		
{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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation indicating 2 of 2 staff had been screened for communicable diseases, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service. Caregiver D was screened for TB 87 days after her/his start date. Caregiver D and Caregiver E were not screened for	{M 232}		

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

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{M 232}	Continued From page 1 communicable diseases. This is a repeat deficiency. See Statement of Deficiency (SOD) 4BQO11, dated 04/02/2025. Findings include: On 04/16/2026, at 2:30 PM, Surveyor reviewed employee records and identified the following: - Caregiver D was hired on 07/08/2025. Caregiver D's record indicated s/he was screened for TB on 10/03/2025, which was 87 days after her/his start date. Caregiver D's record did not contain evidence s/he was screened for communicable diseases. - Caregiver E was hired on 09/16/2025. Caregiver E was screened TB on 09/15/2025. Caregiver E's record did not contain evidence s/he was screened for communicable diseases. On 04/16/2026, at 3:37 PM, Surveyor interviewed Manager A. Manager A confirmed the code requirement. Manager A did not offer any explanation as to why Caregiver D's TB was late. Manager A did not offer an explanation why Caregiver D and Caregiver E's communicable disease screening was missing.	{M 232}		
{M 262}	88.05(2)(a) DIFFICULTY WALKING 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: 1. The exits from the home shall	{M 262}		

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{M 262}	Continued From page 2	{M 262}		

be ramped to grade with a hard surfaced pathway with handrails.
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.
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.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 2 of 2 exits from the home were ramped to grade with a hard surfaced pathway with handrails for residents who walk only with difficulty, or only with the assistance of crutches, a cane, or a walker, or are unable to easily negotiate stairs without assistance. Resident 1 utilized a walker for ambulation.

This is a repeat deficiency. See Statement of Deficiency (SOD) 4BQO11, dated 04/02/2025.

Findings include:

The facility was licensed 03/02/2015, to serve up to 3 ambulatory residents.

Record Review

On 04/16/2026, at 7:00 AM, Surveyor reviewed the Department's file for the facility. Surveyor reviewed a waiver regarding Resident 1's

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{M 262}	Continued From page 3	{M 262}		

utilization of a walker, which was signed by Licensee F on 06/01/2025. On 07/18/2025, the Department requested further information regarding Resident 1. Surveyor was unable to locate evidence the requested information was submitted to the department.

Observations

On 04/16/2026, at 10:50 AM, Surveyor toured the facility and observed the following:

Front Door identified as an emergency exit. There was 1 step up from the driveway to a cement walkway. Once inside the home, there was 1 step up to the living room

Rear Exit identified as an emergency exit. There was 1 step from the house to a concrete platform, which led to 2 more steps to the driveway.

At 11:45 AM, Surveyor observed Resident 1 in her/his bedroom walk to the bathroom utilizing a walker.

Interviews

On 04/16/2026, at 11:25 AM, Surveyor interviewed Caregiver E. Caregiver E confirmed Resident 1 utilized a walker for ambulation. Caregiver E indicated s/he was unaware of how Resident 1 maneuvered the step to exit the facility. Caregiver E stated, "I've never taken [her/him] out of the house, but I would imagine [s/he] would need help."

On 04/16/2026, at 12:55 PM, Surveyor interviewed Resident 1. Resident 1 confirmed s/he used the walker for ambulation. Resident 1

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{M 262}	Continued From page 4 stated, "Yep, I use my walker all the time." On 04/16/2026, at 3:37 PM, Surveyor interviewed Manager A. Manager A reported they had filed a waiver for Resident 1's use of a walker for ambulation. Manager A reported s/he thought if they had a waiver filed, they could continue to allow Resident 1 to stay at the facility. Manager A confirmed they did not have an approved waiver. Manager A reported s/he was unaware of the additional items requested by the department in review of the waiver. Manager A reported they would submit the information to the Department.	{M 262}		
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 the home was clean, well-maintained and a homelike environment for 3 of 3 residents. The kitchen required cleaning. Findings include: On 04/16/2026, at 10:50 AM, Surveyor toured the facility and observed the following in the kitchen: The stove and hood were covered in a slippery	M 276		

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M 276	Continued From page 5 substance similar to oil or grease. The oven contained food splatter. There was a pot on the stove which contained amber colored liquid with food particles inside. The cabinets, specifically the area around the cabinet pulls, contained a darker, sticky material which was scratched away by Surveyor's nail. This material was on 5 upper cabinets. The area was approximately 6 inches by 4 inches. The wall area near the trashcan was covered in brownish substance similar to food splatter. The area measures approximately 24 inches by 18 inches. The kitchen ceiling fan blades contained gray matter similar to dust. The southeast wall contained tuffs of gray matter similar to dust. The wall next to the dining room chair had approximately 7 feet of brown scuffing marks. The heat register in the kitchen appeared rusted and covered in a gray substance similar to dust. The flooring transition from the kitchen floor to the living room carpet was missing, which exposed 34 inches of a metal track. On 04/16/2026, at 3:37 PM, Surveyor interviewed Manager A. Manager A acknowledged Surveyors concerns.	M 276		
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	M 424		

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M 424	Continued From page 6 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. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) individual service plan (ISP) was reviewed and updated when Resident 1 had a change of condition. Resident 1 utilized a walker for ambulation. Findings include: On 04/16/2026, at 11:45 AM, Surveyor observed Resident 1 utilize a walker in her/his bedroom. On 04/16/2026, at 12:17 PM, Surveyor reviewed Resident 1's ISP. Resident 1 was admitted on 02/13/2020 with diagnoses including dementia. Resident 1's ISP was dated 02/13/2026 and indicated under section "Mobility and transferring" Resident 1 could walk and ambulate independently and was independent with all	M 424		

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M 424	Continued From page 7 transfers. Resident 1's ISP did not indicate Resident 1 utilized a walker for ambulation or transfers. On 04/16/2026, at 11:25 AM, Surveyor interviewed Caregiver E. Caregiver E confirmed Resident 1 utilized a walker for ambulation. On 04/16/2026, at 12:55 PM, Surveyor interviewed Resident 1. Resident 1 confirmed s/he used the walker for ambulation. Resident 1 stated, "Yep, I use my walker all the time." On 04/16/2026, at 3:37 PM, Surveyor interviewed Manager A. Manager A acknowledged Surveyor's concerns regarding Resident 1's ISP not containing correct information. Manager A reported s/he would ensure Resident 1's ISP was updated with Resident 1's ability of ambulation and transfers.	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. This Rule is not met as evidenced by:	{M 458}		

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{M 458}	Continued From page 8 Based on observation, record review and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and Resident 2) prescription medications were securely stored. Resident 1's insulin pens were not securely stored in the kitchen refrigerator. The keys to the medication closet were hanging in the kitchen during the survey. This is a repeat deficiency. See Statement of Deficiency (SOD) 4BQO11, dated 04/02/2025. Findings include: On 04/16/2026, at 11:00 AM, Surveyor toured the facility. Surveyor opened the fridge and observed a black lock box. The lock box had a combination lock which was not engaged. Surveyor observed 2 Novolin flex pens and 2 liraglutide pens. Surveyor observed a corkboard in the kitchen. A key was hanging from a push pin attached to a blue silicone type brush. The medication door was locked. Caregiver E confirmed the key was for the medication closet. Surveyor was able to utilize the key to open the medication closet and observed resident prescription medications. Surveyors observed residents moving freely around the facility. During the survey, Caregiver E was in different rooms of the facility, with the medication key on the corkboard in the kitchen. On 04/16/2026, at 3:37 PM, Surveyor interviewed Manager A. Manager A confirmed the code requirement. Manager A reported s/he was unaware the medication key was not to be accessible to residents. Manager A reported s/he had not heard that before from any other surveyor and s/he had "an issue with that." Manager A	{M 458}		

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{M 458}	Continued From page 9 reported they always had the key hanging in all facilities so staff would not lose the key or take the key home. Manager A acknowledged Surveyor's concerns, but reported s/he did not agree. Manager A reported they may need to look at a different system for securing medications to ensure staff had access to medications without lost keys.	{M 458}		