STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015964	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON CRAWFORD HOME (THE)	7305 W CRAWFORD AVENUE MILWAUKEE, WI 53220

(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 10/24/2025, Surveyor conducted a standard survey at Nelson Crawford Home. Five deficiencies were identified. Two of 5 deficiencies were repeat violations. Census: 04	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, initiate other enforcement action provided in this chapter or in ch. 50,	M 114		

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

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M 114	Continued From page 1 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 complete background checks were completed for 2 of 2 employees (Caregiver C and Caregiver D) reviewed. A complete background check consists of the following three parts: 1. A completed Background Information Disclosure (BID) form. 2. A report of findings from the Department of Justice (DOJ). 3. Governmental Findings Report (previously "IBIS letter") from the Department of Health Services. This is a repeat deficiency. See Statement of Deficiency QC5F11, dated 04/19/2021. Findings include: On 01/24/2025, Surveyor reviewed staff files and identified the following: Caregiver C's date of hire was 12/06/2021. Caregiver C's record did not contain a DOJ report or Governmental Findings Report. Caregiver D's date of hire was 09/20/2024. Caregiver D's record did not contain a DOJ report	M 114		

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M 114	Continued From page 2 or Governmental Findings Report. On 10/24/2025, at approximately 1:00 PM, Surveyor interviewed House Manager (HM) B regarding Caregiver C's and Caregiver D's incomplete background checks. HM B reported s/he just recently learned of the DOJ and Governmental Findings Report parts of the requirement but would be sure to get this completed.	M 114		
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:	M 332		

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M 332	Continued From page 3 Based on observation and staff interview, the facility did not ensure 2 of 2 fire extinguishers (main level and basement level extinguishers) were inspected annually by the authorized dealer or the local fire department. Findings include: The facility was licensed on 05/23/2016 to serve up to 4 non-ambulatory advanced aged residents. On 10/24/2025, at approximately 1:15 PM, Surveyor conducted a tour of the facility. During tour, 2 of 2 fire extinguishers were observed to be without a tag indicating they had been inspected annually by the authorized dealer or the local fire department. -One fire extinguisher was located in the kitchen. It had a handwritten sticker affixed by staff with the dates 04/04/2024 indicating a staff member had observed the fire extinguisher to be "full". There was no tag indicated the fire extinguisher had been inspected annually by the authorized dealer or the local fire department. -The fire extinguisher located in the basement had a handwritten sticker affixed by staff with the dates 04/04/2024 indicating a staff member had observed the fire extinguisher to be "full". There was no tag indicated the fire extinguisher had been inspected annually by the authorized dealer or the local fire department. On 10/24/2025, at approximately 1:20 PM, Surveyor interviewed House Manager (HM) B regarding the need to have fire extinguishers inspected by an authorized dealer or the local fire department. They confirmed they were unaware the fire extinguishers were overdue but would have it done immediately.	M 332		

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M 332	Continued From page 4 Cross Reference M 0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing and Maintenance	M 332		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure smoke detectors were maintained in working condition. Two of 6 required smoke detectors were not working. This is a repeat deficiency. See Statement of Deficiency QC5F11, dated 04/19/2021. Findings include: On 10/24/2025, Surveyor completed tour of the facility. The facility is a ranch style home with 4 bedrooms, living room, kitchen, and full basement. During the tour of the facility, the smoke detectors in the living room and basement were tested and found not working. On 10/24/2025, at approximately 1:30 PM, Surveyor interviewed House Manager B and Administrator A and asked if they conducted	M 336		

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M 336	Continued From page 5 monthly testing of all smoke detectors. Administrator A showed Surveyor completed logs which documented all smoke detectors were tested and found working on 10/01/2025. House Manager B stated, "both smoke detector batteries will be replaced." Cross Reference M 0332 88.05(4)(a) Fire Safety - Fire Extinguishers	M 336		
M 402	88.06(2)(c)8 RESIDENT RIGHTS AND GRIEVANCE 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 3) admitted to the home had a statement indicating resident rights and grievance procedures had been explained and copies provided to the residents. Findings include: On 10/24/2025, Surveyor reviewed resident records and identified the following: Resident 1 was admitted to the facility on 08/15/2023. Resident 1's record did not contain evidence of resident rights and grievance procedures explained to them. Resident 2 was admitted to the facility on 04/27/2022, Resident 2's record did not contain	M 402		

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M 402	Continued From page 6 evidence of resident rights and grievance procedures explained to them. On 10/24/2025, at approximately 1:15 PM, Surveyor interviewed House Manager B about reviewing resident rights and grievance procedures with residents. House Manager B stated s/he was not aware of this requirement until very recently but would give the residents a copy of the procedures and update all resident records.	M 402		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure documentation of medication administration for 1 of 1 resident reviewed (Resident 1). There were blank areas on 1 of 1 Medication Administration Record (MAR) where staff would document medication administration. Findings include: On 10/24/2025, Surveyor reviewed Resident 1's	M 466		

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M 466	Continued From page 7 record. Resident 1 was admitted on 08/15/2023. Resident 1's Individual Service Plan (ISP), dated 8/15/2025, identified Resident 1 required medication administration from staff. Resident 1's MAR for October 2025 identified the following: There was no documentation of medication administration or refusals on the following dates and times: -10/22/2025 (8:00 AM): Probiotic Saccharomyce 250 milligrams (mg); Propranolol 20 mg; Senna -S Plus 8.6/50 mg; Sertraline 100 mg; Solifenacin 10 mg; Tamsulosin 0.4 mg; Triamcinolone 0.4% ointment; Vitamin B12 1000 mg; Vitamin C 500 mg; Vitamin D3 2,000U 50 mg; Lomotrigine 50 mg; Pantoprazole 40 mg; Primidone 250 mg; Aspirin 81 mg; Carb/Levo 25/1000 mg; Clopidogrel 75 mg. -10/23/2025 (8:00 AM): Probiotic Saccharomyce 250 milligrams mg; Propranolol 20 mg; Senna -S Plus 8.6/50 mg; Sertraline 100 mg; Solifenacin 10 mg; Tamsulosin 0.4 mg; Triamcinolone 0.4% ointment; Vitamin B12 1000 mg; Vitamin C 500 mg; Vitamin D3 2,000U 50 mg; Lomotrigine 50 mg; Pantoprazole 40 mg; Primidone 250 mg; Aspirin 81 mg; Carb/Levo 25/1000 mg; Clopidogrel 75 mg. -10/24/2025 (8:00 AM): Probiotic Saccharomyce 250 milligrams mg; Propranolol 20 mg; Senna -S Plus 8.6/50 mg; Sertraline 100 mg; Solifenacin 10 mg; Tamsulosin 0.4 mg; Triamcinolone 0.4% ointment; Vitamin B12 1000 mg; Vitamin C 500 mg; Vitamin D3 2,000U 50 mg; Lomotrigine 50 mg; Pantoprazole 40 mg; Primidone 250 mg; Aspirin 81 mg; Carb/Levo 25/1000 mg; Clopidogrel 75 mg.	M 466		

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M 466	Continued From page 8 On 10/24/2025, at approximately 1:30 PM, Surveyor interviewed House Manager B who confirmed Resident 1 required staff administration of medications. House Manager B stated, "These medications were passed but not signed for. I will speak with the responsible staff about the importance of documenting what they administer."	M 466		