STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 03/17/2026, Surveyor completed a standard survey at BKA Family Living Services LLC. As a result, 12 deficiencies were identified. Census: 4	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 ensure all service providers were screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse, or a physician assistant within 90 days before the start of providing service for 1 (Caregiver B) of 2 caregivers reviewed. Findings include: On 03/17/2026 at approximately 10:00 AM, Surveyor reviewed Caregiver B's employee file. Caregiver B was hired on 05/28/2025. Caregiver B's file did not contain evidence that indicated	M 232		

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
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 1 Caregiver B was screened for illness detrimental to residents, including TB. On 03/17/2026 at approximately 10:30 AM, Surveyor interviewed Caregiver B. Caregiver B could not recall if he/she was screened for illness detrimental to residents, including TB within 90 days before the start of providing services. Caregiver B reported having an upcoming medical appointment and will ask to be screened for illness detrimental to residents, including TB. On 03/18/2026 at approximately 10:30 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A acknowledged Caregiver B's employee file did not contain evidence that indicated Caregiver B was screened for illness detrimental to residents, including TB. Assistant Administrator A could not recall if he/she received documents that indicated Caregiver B was screened for illness detrimental to residents, including TB.	M 232		
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.	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 (Caregiver B) of 2 caregivers reviewed received 15 hours of training prior to or within 6 months of hire. Caregiver B did not have evidence of training related to the health, safety, and welfare of residents, fire safety, first aid, and treatment appropriate to residents served prior to or within 6 months of hire. Findings include: On 03/17/2026 at approximately 10:00 AM, Surveyor reviewed Caregiver B's employee file. Caregiver B was hired on 05/28/2025. Caregiver B's file did not include evidence that indicated Caregiver B completed training related to the health, safety, and welfare of residents, fire safety, first aid, and treatment appropriate to residents served prior to or within 6 months of hire. On 03/17/2026 at approximately 10:30 AM, Surveyor interviewed Caregiver B. Caregiver B confirmed he/she did not complete training related to the health, safety, and welfare of residents, fire safety, first aid, and treatment appropriate to residents served prior to or within 6 months of hire. On 03/17/2026 at approximately 10:30 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A acknowledged Caregiver B did not complete training related to the health, safety, and welfare of residents, fire safety, first aid, and treatment appropriate to residents served prior to or within 6 months of hire due to the cost of training. Assistant	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 3 Administrator A is aware of the code requirements requiring caregivers to receive 15 hours of training related to the health, safety, and welfare of residents, fire safety, first aid, and treatment appropriate to residents served prior to or within 6 months of hire.	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each caregiver completed 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights, and treatment of residents for 1 of 1 caregiver reviewed who required annual training. Caregiver C did not receive annual training in 2024 and 2025. Findings include: On 03/17/2026 at approximately 10:00 AM, Surveyor reviewed Caregiver C's employee file. Caregiver C was hired on 08/18/2020. Caregiver C's file did not contain evidence that indicated Caregiver C complete annual training related to	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 246	Continued From page 4 fire safety, first aid, health, safety and welfare of residents, resident rights and treatment appropriate to residents for calendar year 2024 and 2025. On 03/17/2026 at approximately 10:30 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A acknowledged Caregiver C did not complete annual training related to fire safety, first aid, health, safety and welfare of residents, resident rights and treatment appropriate to residents for calendar year 2024 and 2025 due to the cost of training. Assistant Administrator A disclosed Caregiver C worked at another assisted living facility, and believed Caregiver C received training at that facility. Surveyor requested training documents to be emailed to Surveyor by 03/18/2026 at 8:30 AM. As of 03/18/2026 at 1:00 PM, Surveyor had not received any additional training documents.	M 246		
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 provider did not ensure 1 of 1 gas furnace was inspected and serviced every 3 years by a heating contractor or local utility company. Findings include: On 03/18/2026, at approximately 9:30 AM, Surveyor reviewed the adult family home's life safety record. The life safety record did not	M 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 5 contain evidence of a completed furnace inspection within the last 3 years. On 03/18/2026, at approximately 3:42 PM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A reported the furnace was last inspected in 2025, however denied having documentation that indicated the furnace inspection was inspected in 2025. Assistant Administrator A informed Surveyor that he/she would contact the contractor to try and obtain evidence of the completed furnace inspection. Surveyor requested evidence of a completed furnace inspection be emailed to this surveyor by 03/18/2026 at 8:30 AM. As of 03/18/2026 at 1:00 PM, Surveyor had not received evidence of a completed furnace inspection within the last 3 years.	M 290		
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 review the fire safety evacuation plan with 1 (Resident 1 and Resident 2) of 4 residents reviewed immediately following his/her placement.	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 344	Continued From page 6 Resident 1 and Resident 2 did not have a fire evacuation plan within 3 days of admission. Findings include: On 03/17/2026 at approximately 9:30 AM, Surveyor reviewed resident records. The following was identified: Resident 1 was admitted to the facility on 04/04/2025. Resident 1 did not have evidence of a fire safety evacuation plan completed within 3 days of admission. Resident 2 was admitted to the facility on 12/04/2024. Resident 2 did not have evidence of a fire safety evacuation plan completed within 3 days of admission. On 03/17/2026 at 9:30 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A reported due to Resident 1's cognition, Resident 1 would need staff assistance to evacuate the home. Assistant Administrator A acknowledged a fire safety evacuation plan was not completed within 3 days of admission. Assistant Administrator A reported he/she would ensure a fire safety evacuation plan would be completed as soon as possible for Resident 1.	M 344		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 346	Continued From page 7 having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 1 (Resident 2) of 2 residents who lived in the facility beyond one year. Resident 3 did not have an evacuation assessment completed in 2024 and 2025. Findings include: On 03/17/2026, at approximately 9:30 AM, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 03/27/2023. Resident 3's record contained an evacuation evaluation dated 03/24/2023. Resident 3's record did not contain evidence of an updated evaluation in 2024 and 2025. Resident 3's was due for review annually in March. On 03/17/2026, at approximately 10:30 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A acknowledged the code requirements. Assistant Administrator A reported he/she was responsible for ensuring each resident had a completed annual evacuation assessment. Assistant Administrator A did not provide a reason as to why Resident 3 did not have a completed annual evacuation assessment in 2024 and 2025. Assistant Administrator A reported he/she would complete Resident 3's annual evacuation assessment as soon as possible.	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 8	M 380		
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. 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) received a health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission or within 7 days after admission. Findings include: On 03/18/2026 at approximately 9:30 AM, Surveyor reviewed resident records. The following was identified: Resident 1 was admitted to the facility on 04/04/2025. Resident 1's record did not include evidence of a health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission 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
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 9 Resident 2 was admitted to the facility on 12/04/2024. Resident 2's record did not include evidence of a health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission or within 7 days after admission. Resident 4 was admitted to the facility on 03/26/2025. Resident 4's record did not include evidence of a health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission or within 7 days after admission. On 03/17/2026 at approximately 10:30 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A acknowledged Resident 1's, Resident 2's, and Resident 4's records did not contain evidence of a completed health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission or within 7 days after admission. Assistant Administrator A acknowledged each resident has seen their primary care physician since admission, but was not sure why each resident was not screened for communicable disease, including tuberculosis (TB), within 90 days prior to admission or within 7 days after admission.	M 380		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be	M 384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 384	Continued From page 10 completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an admission agreement was signed by the resident for 4 (Resident 1, Resident 2, Resident 3, and Resident 4) of 4 residents. Findings include: On 03/18/2026 at approximately 9:30 AM, Surveyor reviewed resident's records. The following was identified: Resident 1 was admitted to the facility on 04/04/2025. Resident 1's record did not contain a signed admission agreement Resident 2 was admitted to the facility on 12/04/2024. Resident 2's record did not contain a signed admission agreement Resident 3 was admitted to the facility on 03/27/2023. Resident 3's record did not contain a signed admission agreement Resident 4 was admitted to the facility on 03/26/2025. Resident 4's record did not contain a signed admission agreement. On 03/17/2026 at approximately 10:30 AM, Surveyor interviewed Assistant Administrator A.	M 384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 384	Continued From page 11 Assistant Administrator A reported he/she was responsible for ensuring each resident has a signed admission agreement. Assistant Administrator A acknowledged each resident did not have a signed admission agreement. Assistant Administrator A did not know why each resident did not have a signed admission agreement. Assistant Administrator A stated he/she would work on getting a signed admission agreement for each resident.	M 384		
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 1 (Resident 1) of 4 residents admitted to the home had a statement indicating resident rights and grievance procedures had been explained and copies provided to the resident. Findings include: On 03/17/2026 at approximately 9:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/04/2025. Resident 1's record did not contain evidence of resident rights and grievance procedures explained with Resident 1. On 03/17/2026 at approximately 10:30 AM,	M 402		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 402	Continued From page 12 Surveyor interviewed Assistant Administrator A. Assistant Administrator A reported being aware of the code requirements but could not state why Resident 1's record did not contain evidence of resident rights and grievance procedures explained with Resident 1. Assistant Administrator A reported he/she would ensure Resident 1's contained evidence of resident rights and grievance procedures explained with Resident 1.	M 402		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written assessment and individual service plan (ISP) was completed for 4 (Resident 1, Resident 2, Resident 3, and Resident 4) of 4 residents within 30 days of placement. Findings include: On 03/17/2026 at approximately 9:30 AM, Surveyor reviewed resident's records. The following was identified: Resident 1 was admitted to the facility on 04/04/2025. Resident 1's record did not contain a	M 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 404	Continued From page 13 written assessment or an ISP. Resident 2 was admitted to the facility on 12/04/2024. Resident 2's record did not contain a written assessment or an ISP. Resident 3 was admitted to the facility on 03/27/2023. Resident 3's record did not contain a written assessment or an ISP. Resident 4 was admitted to the facility on 03/26/2025. Resident 4's record did not contain a written assessment or an ISP. On 03/17/2026 at approximately 10:30 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A reported the facility has always used the Member Centered Plan that is provided by the Managed Care Organization (MCO) as the ISP for each resident. Assistant Administrator A acknowledged the Member Centered Plan is not comprehensive or inclusive of what the code requires. Assistant Administrator A reported he/she would start working on developing and completing an ISP for each resident.	M 404		
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.	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 14 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 for 2 (Resident 1 and Resident 2) of 4 residents who required staff to administer their medications. Resident 1 and Resident 2 did not have a written order permitting the provider staff to administer medications. Findings include: On 03/17/2026 at approximately 9:30 AM, Surveyor reviewed resident's records. The following was identified: Resident 1 was admitted to the facility on 04/04/2025. Resident 1 did not have evidence of written orders from his/her physician permitting the provider staff to administer his/her medications. Resident 2 was admitted to the facility on 12/04/2024. Resident 2 did not have evidence of written orders from his/her physician permitting the provider staff to administer his/her medications. On 03/17/2026 at approximately 10:30 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A confirmed facility staff managed and administered Resident 1's and Resident 2's prescribed medication(s). Assistant Administrator A acknowledged Resident 1 and	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 15 Resident 2 did not have a written order permitting the provider staff to administer medications. Assistant Administrator A reported sending the forms to Resident 1's and Resident 2's primary care providers, but did not follow up with the clinics to ensure completion. Assistant Administrator A stated he/she would work on getting written orders permitting the provider staff to administer medications for Resident 1 and Resident 2.	M 464		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure 1 (Resident 3) of 4 residents received prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 did not receive prescribed medications in the correct dosage as prescribed by his/her physician 16 times between 02/19/2026 and 03/18/2026.	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 582	Continued From page 16 Findings include: On 03/18/2026 at approximately 9:00 AM, Surveyor toured the medication closet with Assistant Administrator A. Surveyor identified the following: Resident 1's shelf contained 2 weekly bubble packed medications. The 2-weekly bubble packed medications was dated 02/26/2026 to 03/04/2026 and 03/05/2026 to 03/11/2026. Resident 1's weekly bubble pack dated 02/26/2025 to 03/04/2026 contained 5 unopened packs of prescribed medications. Two of the 5 unopened packs were dated 03/01/2026. The first unopened pack labeled "Morning, 03/01/2026" contained 1 - topiramate 25 milligram (mg) tablet, 1 - gabapentin 300 mg capsule, 1 - prednisone 5 mg tablet. The second unopened pack labeled "Noon, 03/01/2026" contained 3 - mycophenolate 500 mg tablets, 1 - amlodipine 5 mg tablet, 1 - furosemide 20 mg tablet, 1 hydroxychloroquine 300 mg tablet, and 1 - Pantoprazole 20 mg tablet. Three of the 5 unopened packs were dated 03/02/2026. The first unopened pack labeled "Morning, 03/02/2026" contained 1 - topiramate 25 mg tablet, 1 - gabapentin 300 mg capsule, 1 - prednisone 5 mg tablet. The second unopened pack labeled "Noon, 03/02/2026" contained 3 - mycophenolate 500 mg tablets, 1 - amlodipine 5 mg tablet, 1 - furosemide 20 mg tablet, 1 hydroxychloroquine 300 mg tablet, and 1 - pantoprazole 20 mg tablet. The third unopened pack labeled "Night, 03/02/2026" contained 3 - mycophenolate 500 mg tablets, 1 - gabapentin 300 mg tablet, 1 - trazadone 50 mg tablet, and 1 -atorvastatin 40 mg tablet.	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 582	Continued From page 17	M 582		

Resident 1 had a single unopened bubble pack, not attached to the weekly bubble pack dated for "evening 03/04/2026." The unopened bubble pack contained 1 gabapentin 300 milligrams capsule, 3 mycophenolate 500 mg tablets, and 1 tamsulosin 0.4mg caps.

Resident 1's weekly bubble pack dated 03/05/2026 to 03/11/2026 contained 9 unopened packs of prescribed medications. One of the 9 unopened packs was dated 03/06/2026. The first unopened pack labeled "Morning, 03/06/2026" contained 1 - topiramate 25 mg tablet, 1 - gabapentin 300 mg capsule, 1 - prednisone 5 mg tablet. Two of the 9 unopened packs were dated 03/07/2026. The first unopened pack labeled "Morning, 03/07/2026" contained 1 - topiramate 25 mg tablet, 1 - gabapentin 300 mg capsule, 1 - prednisone 5 mg tablet. The second unopened pack labeled "Noon, 03/07/2026" contained 3 - mycophenolate 500 mg tablets, 1 - gabapentin 300 mg tablet, and 1 - tamsulosin 0.4 mg tablet. Three of the 9 unopened packs were dated 03/10/2026. The first unopened pack labeled, "Morning, 03/10/2026" contained 1 - topiramate 25 mg tablet, 1 - gabapentin 300 mg capsule, 1 - prednisone 5 mg tablet. The second unopened pack labeled, "Noon, 03/10/2026" contained 3 - mycophenolate 500 mg tablets, 1 - gabapentin 300 mg tablet, and 1 - tamsulosin 0.4 mg tablet. The third unopened pack labeled "Night, 03/10/2026" contained 3 - mycophenolate 500 mg tablets, 1 - gabapentin 300 mg tablet, 1 - trazadone 50 mg tablet, 1 -atorvastatin 40 mg tablet, and 1 - amlodipine 5 mg tablet. Three of the 9 unopened packs were dated 03/11/2026. The first unopened pack labeled, "Morning, 03/10/2026" contained 1 - topiramate 25 mg tablet, 1 - gabapentin 300 mg capsule, 1 - prednisone 5 mg tablet. The second unopened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 582	Continued From page 18	M 582		

pack labeled, "Noon, 03/10/2026" contained 3 - mycophenolate 500 mg tablets, 1 - gabapentin 300 mg tablet, and 1 - tamsulosin 0.4 mg tablet. The third unopened pack labeled "Night, 03/10/2026" contained 3 - mycophenolate 500 mg tablets, 1 - gabapentin 300 mg tablet, 1 - trazadone 50 mg tablet, 1 -atorvastatin 40 mg tablet, and 1 - amlodipine 5 mg tablet.

Resident 1 had a single unopened bubble pack, not attached to the weekly bubble pack dated for "Morning, 03/14/2026." The unopened bubble pack contained 1 - amlodipine besylate 5 mg tablet, 1 - furosemide 20 mg tablet, 1 gabapentin 300 milligrams capsule, 1 - hydroxychloroquine 300 mg tablet, 3 mycophenolate 500 mg tablets, 1 pantoprazole 20 mg tablet, 1 - prednisone 5 mg tablet, and 1 topiramate 25 mg tablet, and 1 vitamin B-1 100 mg tablet.

On 03/18/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 03/27/2023. Resident 1's medication administration record with a "Print Date Range" of 02/17/2026 to 03/16/2026 contained 265 blank spots indicating medications were not signed out or given to Resident 1.

On 03/18/2026 at approximately 9:00 AM, Surveyor interviewed Assistant Administrator A. Assistant Administrator A confirmed facility staff managed and administered Resident 1's medications. Assistant Administrator A acknowledged the blank spaces. Assistant Administrator A admitted staff do not always sign out medications after they are given. In addition, Assistant Administrator A reported Resident 1 often refused his/her medications or Resident 1 leaves the facility for the day, and the medications would be given to him/her to take while he/she is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015937	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BKA FAMILY LIVING SERVICES LLC	1532 W CAPITOL DR MILWAUKEE, WI 53206

(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 582	Continued From page 19 out of the facility. Assistant Administrator A confirmed being aware of the code requirements when the provider manages a resident's prescribed medication. Assistant Administrator A reported staff should be signing out the medications after it is being given, or documenting when Resident 1 refused his/her medication(s).	M 582		