STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015713	A. BUILDING: _____ B. WING _____	R-C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD HOUSE OF WAUKESHA CORP SHI	8860 S SHEPARD AVE OAK CREEK, WI 53154

(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 04/24/2026 with information gathered through 04/28/2026, Surveyor conducted a standard survey and verification visit for Statement of Deficiency (SOD) WXXX11, dated 02/17/2025, at Oakwood House of Waukesha Corp Shepard, an Adult Family Home (AFH) in Oak Creek, WI. One of 1 deficiency was corrected from SOD WXXX11. Ten new deficiencies were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. 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 2 of 2 service providers (Caregiver H and Caregiver I) were screened for illness detrimental to residents, including tuberculosis (TB). Caregiver H's and Caregiver I's	M 232		

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

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M 232	Continued From page 1 records did not contain documentation of being screened for illness detrimental to residents or TB test results. Findings include: On 04/24/2026, Surveyor reviewed Caregiver H's and Caregiver I's records and identified the following: Caregiver H -Caregiver H was hired on 10/19/2024. Caregiver H's employee record did not contain documentation s/he was screened for illness detrimental to residents or TB results. Caregiver I -Caregiver I was hired on 04/20/2026. Caregiver I's employee record did not contain documentation s/he was screened for illness detrimental to residents or TB results. On 04/24/2026, at approximately 1:34 PM, Surveyor interviewed Administrative Assistant (AA) B. AA B confirmed Caregiver H's and Caregiver I's records did not contain documentation of being screened for illness detrimental to residents or TB test results. AA B reported moving forward s/he will ensure staff are 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	M 244		

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M 244	Continued From page 2 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: Based on record review and interview, the provider did not ensure 1 of 1 service provider (Caregiver H) received training within 6 months after starting to provide care related to health, safety and welfare of residents, resident rights and treatment appropriate to residents. Findings include: On 04/24/2026, Surveyor reviewed Caregiver H's record and identified the following: -Caregiver H was hired on 10/19/2024. -Caregiver H's employee record did not contain evidence of training related to health, safety and welfare of residents, resident rights and treatment appropriate to residents. On 04/24/2026, at approximately 1:34 PM, Surveyor interviewed Administrative Assistant (AA) B. AA B confirmed Caregiver H's record did not contain evidence of the above-mentioned training. AA B reported moving forward s/he will ensure service providers receive required training.	M 244		

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M 262	Continued From page 3	M 262		
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 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 1 of 2 ramps were to grade with a hard surfaced pathway. This facility has a Semi-Ambulatory license, and the rear ramp was not equipped for semi-ambulatory residents. The rear ramp needed maintenance. Findings include: This facility was issued an ambulatory license on 07/22/2015 to serve up to 4 residents within the following client groups: emotionally disturbed/mental illness and developmentally	M 262		

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M 262	Continued From page 4 disabled. On 04/24/2026, Surveyor completed a review of the Department facility folder and identified the following: -On 08/18/2017, the Department granted a license amendment to change ambulation status to ambulatory with conditions for this facility. This facility may accept residents able to walk with difficulty or only with the assistance of an aid such as crutches, cane, or walker. On 04/24/2026, at approximately 1:43 PM, Surveyor toured the facility with Administrative Assistant (AA) B and observed the following: -Square at bottom -- landing of ramp--2 feet 7 inches by 3 feet. The dip is about 2 inches. The landing at the end of the ramp measured 2 feet 7 inches long by 3 feet wide and was sunken into the ground by 2 inches. To navigate to the hard surfaced pathway, residents would have to get to the landing at the end of the ramp and pivot to the left to continue onto the hard surfaced pathway to the front of the house. On 04/24/2026, at approximately 1:48 PM, Surveyor interviewed AA B. AA B did not have an explanation as to why the condition of the ramp was not safe. AA B reported s/he would correct the identified issue.	M 262		
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	M 332		

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M 332	Continued From page 5	M 332		

floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 1 of 2 fire extinguishers were mounted. The fire extinguisher located in the basement was not mounted.

Findings include:

The facility is licensed to provide services for up to 4 residents with client groups of developmentally disabled and emotionally disturbed/mental illness.

On 04/24/2026, at approximately 1:43 PM, Surveyor toured the facility with Administrative Assistant (AA) B and observed the following:

-The fire extinguisher located in the basement was not mounted (fire extinguisher and bracket

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M 332	Continued From page 6 was sitting on the table located in the basement). On 04/24/2026, at approximately 1:48 PM, Surveyor interviewed AA B. AA B confirmed the fire extinguisher located in the basement was not mounted. AA B reported s/he would have the maintenance person mount the fire extinguisher in the basement.	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 record review and interview, the provider did not ensure monthly smoke detector testing for 2 of 2 years (2024, 2025, and to date in 2026) reviewed. Findings include: The facility is licensed to provide services for up to 4 residents with client groups of developmentally disabled and emotionally disturbed/mental illness. On 04/24/2026, Surveyor requested to review smoke detector testing for 2024, 2025 and to date in 2026 from Administrative Assistant (AA) B.	M 336		

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M 336	Continued From page 7 On 04/24/2026, at approximately 8:53 AM, Surveyor reviewed the provider's smoke detector logs and the following was identified: -There was no evidence smoke detectors were checked in 01/2026, 02/2026 and 03/2026. On 04/24/2026, at approximately 9:00 AM, Surveyor interviewed AA B. AA B confirmed the requirement to ensure smoke detectors were tested monthly. AA B stated s/he had a lot to handle at this facility and s/he did not keep up with the testing. CROSS REFERENCE M 332 88.05(4)(a) - Fire Safety - Fire Extinguishers	M 336		
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 ensure 1 of 2 residents (Resident 3) reviewed were evaluated within 3 days of admission for evacuation time, using the department's form, for evacuation.	M 344		

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M 344	Continued From page 8 Findings include: On 04/24/2026, Surveyor reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 11/07/2025. -Resident 3's Resident Evacuation Assessment, dated 03/25/2026, was missing pages 3 of 5, 4 of 5 and 5 of 5. -Resident 3's Resident Evacuation Assessment, dated 03/25/2026, was incomplete. On 04/24/2026, at approximately 10:46 AM, Surveyor interviewed Administrative Assistant (AA) B. AA B confirmed Resident 3's evacuation assessment was incomplete. AA B reported s/he did not realize Resident 3's evacuation assessment was not completed. AA B reported moving forward s/he would ensure all residents had a evacuation assessment completed within 3 days of admission.	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 having an evacuation time of more than 2 minutes.	M 346		

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M 346	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 2) reviewed was evaluated annually for evacuation time, using the Department's form. Resident 2 had not been evaluated for evacuation for calendar years 2024 and 2025 using the Department's form. Findings include: The facility is licensed to provide services for up to 4 residents with client groups of developmentally disabled and emotionally disturbed/mental illness. On 04/24/2026, Surveyor reviewed Resident 2's record. Resident 2's record indicated the following: -Resident 2 was admitted to the provider's home on 07/22/2015. Resident 2's record did not contain evidence of an evacuation assessment for calendar years 2024 and 2025 using the Department's form. On 04/24/2026, at approximately 12:15 PM, Surveyor interviewed Administrative Assistant (AA) B. AA B stated s/he was aware of this requirement to complete the evacuation assessments annually. AA B stated moving forward s/he will ensure residents were evaluated annually for evacuation time, using the Department's form. CROSS REFERENCE M 344 88.05(4)(d)2.a Fire Safety Evacuation Plan Review	M 346		

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M 380	Continued From page 10	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 2 of 2 residents (Resident 2 and Resident 3) were screened for communicable disease within 90 days prior to admission to the home or within 7 days after admission. Findings include: On 04/24/2026, Surveyor reviewed resident records and identified the following: Resident 2 -Resident 2 was admitted to the provider's home on 07/22/2015. -Resident 2's record did not include evidence of a communicable disease screening. Resident 3 -Resident 3 was admitted to the provider's home	M 380		

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M 380	Continued From page 11 on 11/07/2025. -Resident 3's record did not include evidence of a communicable disease screening. On 04/24/2026, at approximately 10:41 AM, Surveyor interviewed Administrative Assistant (AA) B. AA B confirmed Resident 2's and Resident 3's records did not include evidence residents were screened for communicable disease. AA B reported s/he was not aware of this requirement.	M 380		
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 1 of 2 residents (Resident 3) had a written assessment and individual service plan (ISP) completed and developed within 30 days after admission. Findings include: On 04/24/2026, Surveyor reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 11/07/2025.	M 404		

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M 404	Continued From page 12 -Resident 3's record did not contain a written assessment and individual service plan (ISP). The assessment and individual service plan (ISP) was not completed and developed within 30 days after admission. On 04/24/2026, at approximately 8:43 AM, Surveyor interviewed Administrative Assistant (AA) B. AA B reported s/he did not complete a written assessment and ISP for Resident 3. AA B reported s/he was responsible for the assessments and creating ISPs. AA B reported s/he forgot due to being busy completing other job responsibilities. AA B reported s/he was aware of the requirement and moving forward s/he would ensure all residents have a written assessment and ISP within 30 days after admission.	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. 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	M 464		

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M 464	Continued From page 13 provider did not obtain a written order from the physician specifying who by name or position could administer medications for 2 of 2 residents (Resident 2 and Resident 3) reviewed who required staff to administer his/her medications. Resident 2 and Resident 3 did not have a written order permitting the provider staff to administer medications. Findings include: On 04/24/2026, Surveyor reviewed Resident 2's and Resident 3's records and identified the following: Resident 2 -Resident 2 was admitted to the provider's home on 07/22/2015. -Resident 2 did not have an order specifying who by name or position could administer his/her medication. Resident 3 -Resident 3 was admitted to the provider's home on 11/07/2025. -Resident 3 did not have an order specifying who by name or position could administer his/her medication. On 04/24/2026, at approximately 1:48 PM, Surveyor interviewed Administrative Assistant (AA) B. AA B confirmed Resident 2 and Resident 3 required staff to administer their medication. AA B confirmed Resident 2's and Resident 3's records did not contain evidence of a written order permitting the provider staff to administer medications from the physician for Resident 2 and Resident 3.	M 464		

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