STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016566	A. BUILDING: _____ B. WING _____	08/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HANDS ADULT FAMILY HOMES LLC	4444 N 46TH ST MILWAUKEE, WI 53218

(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 08/12/2026, Surveyor concluded an abbreviated survey at Golden Hands Adult Family Homes LLC. Eight 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 obtain documentation indicating staff had been screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service for 2 of 2 staff reviewed (Caregiver B and Caregiver C). This is a repeat deficiency. See Statement of Deficiency CVRZ11, dated 07/13/2021.	M 232		

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

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M 232	Continued From page 1 Findings include: Caregiver B was hired 07/01/2023. Caregiver B started working with the residents in the home on 07/01/2023. Caregiver B was tested for tuberculosis (TB) on 09/07/2023. Caregiver B's screening for communicable disease was dated 09/10/2023. Caregiver B's record did not contain a TB skin test within 90 days before the start of providing service. Caregiver C was hired on 07/01/2023. Caregiver C started working with the residents in the home on 07/01/2023. Caregiver C was tested for tuberculosis (TB) on 09/13/2023. Caregiver C's screening for communicable disease was dated 09/10/2023. Caregiver C's record did not contain a TB skin test 90 days before the start of providing service. On 08/12/2026 at 2:00 p.m., Surveyor interviewed Licensee A, who confirmed Caregiver B and Caregiver C were not screened for illness detrimental to residents, including tuberculosis (TB) or have their communicable disease screenings completed within 90 days prior to the start of service. Licensee A stated, "I thought I had them done according to code."	M 232		
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	M 235		

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M 235	Continued From page 2 blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 service providers received annual 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. Caregiver B and Caregiver C did not complete initial training in universal precautions before beginning to provide services. Findings include: On 08/12/2026 at 1:45 p.m., Surveyor reviewed Caregiver records. The following was identified: Caregiver B was hired 07/01/2023. Caregiver B started working with the residents in the home on 07/01/2023. Caregiver B's file did not contain evidence of standard precautions training before beginning to provide service on 07/01/2023. Caregiver B had standard precautions training on 09/06/2023. Caregiver C was hired on 07/01/2023. Caregiver C's file did not contain evidence of standard precautions training before beginning to provide service on 07/01/2023. Caregiver C had standard precautions training on 09/06/2023. On 08/12/2026 at 2:15 p.m., Licensee A confirmed s/he checked Caregiver B and Caregiver C's certified nursing assistant (CNA) certification. Caregiver B and Caregiver C's on-line record did not contain licensure for CNA	M 235		

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M 235	Continued From page 3 certification. On 08/12/2026 at 2:20 p.m., Surveyor interviewed Licensee A. Licensee A stated, "I did not realize it was supposed to be done before they started on the floor." Licensee A confirmed the Caregiver's may encounter bloodborne pathogens completing caregiver job duties.	M 235		
M 278	88.05(3)(b) FREE OF HAZARDS The home shall be free from hazards and kept uncluttered and free of dangerous substances, insects and rodents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard residents who cannot fully guard themselves from environmental hazards. The clothes dryer was not completely vented with rigid metal tubing. Findings include: On 08/12/2026 at 11:50 a.m., Surveyor toured the facility. While touring the provider's laundry room, Surveyor observed a flexible aluminum foil duct for dryer vent tubing. On 08/12/2026 at 11:52 a.m., Surveyor interviewed Licensee A and asked if the dryer had recent repairs. Licensee A confirmed the dryer contained flexible aluminum foil duct for dryer	M 278		

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M 278	Continued From page 4 vent tubing. Licensee A confirmed having a new dryer put in after a flood a couple of years ago. Licensee A pointed to the dryer tubing that s/he had before the new dryer was installed. Licensee A stated, "I'm so frustrated. I told them that was the tube I needed. I should have followed up."	M 278		
M 312	88.05(3)(h)6 SPACE FOR INDIVIDUAL STORAGE Each resident shall be provided conveniently located individual storage space in the resident's bedroom sufficient for hanging clothes and for storing clothing, toilet articles, towels and other personal belongings. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure sufficient space in each bedroom for storing clothing for 1 of 1 resident. There was no storage space sufficient for hanging clothes in Resident 1's bedroom. Resident 1's closet was locked and his/her dresser was locked in the closet. Findings include: On 08/12/2026, at 12:34 p.m., Surveyor toured Resident 1's bedroom. Surveyor did not observe storage space sufficient for hanging clothes in Resident 1's bedroom. Surveyor noted the room had a bed and books on the floor. On 08/12/2026, at 12:36 p.m., Surveyor interviewed Licensee A, who stated Resident 1 throws his/her things out the window and rips up his/her clothing. Licensee A stated s/he put	M 312		

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M 312	Continued From page 5 Resident 1's dresser in his/her closet because s/he ruins his/her clothes and then does not have any. Licensee A further stated, "His/Her guardian does not send money, and I have been paying for his/her clothing. I had to do something." Cross Reference: M 0560 DHS 88.10(3)(g) Clothing And Possessions	M 312		
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: Based on observation and interview, the provider did not ensure extinguishers were located on	M 332		

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M 332	Continued From page 6 each floor of the facility for 1 of 3 floors. There was no fire extinguisher in the basement. The third-floor fire extinguisher was not mounted. Findings include: On 08/12/2026, at 11:45 a.m., Surveyor toured the facility's physical environment with Licensee A. Surveyor observed that there was not a fire extinguisher in the basement. On 08/12/2026, at 11:45 a.m., Surveyor interviewed Licensee A and asked him/her to identify the location of the fire extinguisher in the basement. Licensee A stated, "There is not a fire extinguisher in the basement." On 08/12/2026, at 12:56 p.m., Surveyor toured the third floor with Licensee A, who stated, "I have a fire extinguisher up here. It's just on the floor." On 08/09/2024, at 4:05 p.m., Surveyor reviewed the code requirements with Licensee A, who confirmed understanding the code required a mounted fire extinguisher on each floor of the facility.	M 332		
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	M 334		

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M 334	Continued From page 7 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 that each required smoke detector was in working condition. The smoke detector in the basement did not function and was emitting a chirping sound. Findings include: On 08/12/2026, at 11:43 a.m., Surveyor toured the home with Licensee A and observed the following: -The smoke detector in the basement was flashing and emitting a chirping sound. On 08/12/2026, at 11:45 a.m., Surveyor toured the basement with Licensee A, who confirmed hearing the smoke detector in the basement emitting a chirping sound. On 08/12/2026, at 11:46 a.m., Surveyor asked why the smoke detector was beeping. Licensee A took the smoke detector down and stated, "The maintenance person was supposed to change the batteries. I wonder if these are the cheap one's and they wear out fast."	M 334		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION	M 346		

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M 346	Continued From page 8 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. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 4 residents were evaluated annually for evacuation time, using the Department's form (Resident 2). Findings include: On 08/12/2026, at 1:05 p.m., Surveyor reviewed resident records and identified the following: Resident 2 was admitted on 08/11/2024 with diagnoses of dementia. Surveyor observed a fire evacuation evaluation dated 08/16/2024. Resident 2's record did not contain a fire evacuation evaluation form for 2025. On 06/05/2026, at 3:45 p.m., Surveyor interviewed Licensee A, who acknowledged s/he was aware of the requirement to assess each resident annually. Licensee A acknowledged the assessments had not been completed. Licensee A stated, "I must have intended to fill it out and I forgot."	M 346		
M 560	88.10(3)(g) Clothing and Possessions Clothing and possessions. To retain and use personal clothing and effects and to retain, as space permits, other	M 560		

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M 560	Continued From page 9	M 560		

personal possessions in a reasonable secure manner.

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) clothing and possessions were accessible. Resident 1's clothing was kept locked in his/her bedroom closet, where Resident 1 could not access them.

Findings include:

On 08/12/2026 at 12:34 p.m., Surveyor toured the home and observed Resident 1's room with just a bed and books on the floor. Resident 1's room did not contain a dresser to store his/her clothing and personal items. Surveyor observed an engaged lock on Resident 1's closet door.

On 08/12/2026 at 1:23 p.m., Surveyor reviewed Resident 1's record. The following was identified: Resident 1 was admitted via protective placement on 05/30/2025 with diagnose degenerative brain disorder. Resident 1 had a guardian. Resident 1's individualized service plan (ISP), dated 05/13/2026, did not identify Resident 1's clothes were to be locked up due to her/his behaviors, including ripping up his/her clothing and throwing them out the window.

On 08/12/2026 at 12:36 p.m., Surveyor interviewed Licensee A, who stated Resident 1 went in and out of his/her closet and pulled everything out and threw everything everywhere, when the closet was not locked. Licensee A reported Resident 1 would shred his/her clothing and throw things out his/her window. Licensee A stated, "I did not know what else to do. So, we locked his/her things up and opened the closet

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M 560	Continued From page 10 when s/he would get dressed." Cross Reference: M0312 88.05(3)(h)6 Space For Individual Storage	M 560		