STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017852	A. BUILDING: _____ B. WING _____	R-C 08/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIV WELL ADULT FAMILY HOMES LLC	8543 W LAWRENCE AVE MILWAUKEE, WI 53225

(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 08/21/2026, Surveyors completed a verification visit and complaint survey at Liv Well Adult Family Homes LLC. As a result, 1 deficiency was identified. One of 1 complaint was unsubstantiated. One of 1 deficiency is being cited for a third time (see Statement of Deficiencies (SODs) DGU912, dated 04/29/2025 and SOD DGU913, dated 12/18/2025). Under statutory provisions of Wis. Stat. C. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
{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: Based on observation and interview, the provider did not ensure every prescription medication was securely stored. Resident 2's and Resident 4's insulin pens were not securely stored.	{M 458}		

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

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{M 458}	Continued From page 1 This requirement is being cited for a third time. See Statement of Deficiencies (SOD) DGU912, dated 04/29/2025 and SOD DGU913, dated 12/18/2025. Findings include: The facility is licensed to provide services for up to 4 ambulatory residents with client groups of emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and advanced aged. On 08/20/2026, at approximately 1:30 PM, Surveyor toured the dining room. Within the dining room was a built-in shelf that contained two sliding glass doors. The doors were not equipped with a lock. Surveyor was able to open the glass door without the use of a key. Within the built-in shelf contained a clear tinted plastic container, and two prescription bottles that contained medication. The clear tinted plastic container had insulin supplies (test strips and needles) and 3 in-use insulin pens. One insulin pen belonged to Resident 2 and two insulin pens belonged to Resident 4. The two prescriptions bottles belonged to Resident 4. On 08/20/2026 at approximately 2:00 PM, Surveyor interviewed Caregiver B. Caregiver B disclosed the two prescriptions bottles were found within Resident 4's bedroom during the morning on 08/20/2026. Caregiver B placed the two prescription bottles in the built-in shelf. Caregiver B reported the insulin pens were placed within the built-in shelf as it was more convenient for staff. Caregiver B stated each resident has their blood sugar checked multiple times a day and receives insulin multiple times a day. Caregiver B understood each prescribed medication should be stored in a secure location.	{M 458}		

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{M 458}	Continued From page 2 On 08/21/2026 at approximately 9:32 AM, Surveyor interviewed Licensee A. Licensee A was not aware staff kept the insulin pens within the built-in shelf. Licensee A confirmed the built-in shelf is not equipped with a lock. Licensee A reported having multiple conversations with staff about the importance of keeping medications locked within the medication closet. Licensee A stated he/she would have to move forward with disciplinary actions as the additional conversation and training do not seem to be effective.	{M 458}		