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(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 06/05/2026, Surveyor concluded a standard survey at Infinity Home Health Care. Nine deficiencies were identified. Census: 3	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 1 of 1 service provider had a complete background check. Caregiver C did not have a complete background check. A complete background check consists of the following: - A completed Background Information Disclosure (BID) form. - A report on the findings from the Department of Justice (DOJ). - A Governmental Findings Report (previously "IBIS letter") from DHS that reports the person's status, including administrative finding or licensing restrictions. Findings include: On 06/05/2026, at approximately 11:55 a.m., Surveyor reviewed Caregiver C's records. The following was identified: Caregiver C was hired on 06/15/2024. Caregiver C's file contained a BID form, dated 11/01/2024. Caregiver C's file contained a DOJ and a Governmental Findings Report dated 06/05/2026. On 06/05/2026, at approximately 12:10 p.m.,	M 114		

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M 114	Continued From page 2 Licensee A stated s/he ran Caregiver C's DOJ report and Governmental Findings Report because s/he could not find them in Caregiver C's file. Licensee A stated the manager at the time of hire was supposed to handle obtaining that information. Caregiver C worked for almost 2 years in the facility without a criminal background check completed.	M 114		
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	M 262		

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M 262	Continued From page 3	M 262		

did not ensure that there were 2 exit doors used by residents who were not able to walk at all, with a clear opening of at least 32 inches. 1 of 2 emergency exit doors did not have a clear opening of 32 inches. The back emergency exit door had a clear opening of 29-inches.

Resident 2 required a motorized wheelchair for propulsion. Resident 3 required a motorized wheelchair for propulsion.

Findings include:

This facility was licensed on 05/02/2021 to serve up to 3 ambulatory residents and 1 non-ambulatory resident with residents in the client groups of advanced aged, irreversible dementia/Alzheimer's, developmentally disabled, physically disabled, emotionally disturbed/mental illness, and traumatic brain injury.

On 06/05/2026 at 8:40 a.m., Surveyor toured the home and observed the following:

- Resident 2 was sitting in his/her motorized wheelchair.
- Resident 3 was in his/her bed, with his/her motorized wheelchair nearby.

-The posted exit plan identified two emergency exits; one was at the front door of the facility, and another was the side exit door, that entered the kitchen.

On 06/05/2026 at 11:45 a.m., Surveyor and Licensee A measured the back exit door. Licensee A confirmed the back emergency exit door measured a clear opening of 29-inches.

On 06/05/2026 at 11:45 a.m., Surveyor

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M 262	Continued From page 4 interviewed Licensee A, who stated s/he was not aware that the side exit door measured 29-inches.	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 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 serviced on each floor of the facility for 1 of 3 floors. The fire extinguishers on the third floor had not been serviced since September 2024. Findings include:	M 332		

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M 332	Continued From page 5 On 06/05/2026, at 9:15 a.m., Surveyor toured the facility's physical environment with House Lead (HL) B. Surveyor observed that the fire extinguishers on the third floor had not been serviced since September 2024. On 06/05/2026, at 1:40 p.m., Surveyor interviewed Licensee A who confirmed the 3rd floor fire extinguisher was overdue. Licensee A stated, "I am the one who takes the fire extinguishers in to get renewed. I did not remember to get that one done."	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 the smoke detectors were tested monthly for 7 of 7 smoke detectors in 2025. Findings include: On 06/05/2026, at 12:00 p.m., Surveyor requested 2025 monthly smoke detector testing documentation. Licensee A provided	M 336		

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M 336	Continued From page 6 documentation for smoke detector testing dated from January 2025 to June 2025. On 06/05/2026, at 12:05 p.m., Surveyor interviewed Licensee A, who reported s/he did not conduct all the monthly smoke detector testing in 2025. Licensee A reported s/he did not document the monthly smoke detector testing. Licensee A stated, "Well, I don't have all of 2025 done."	M 336		
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. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 3 of 3 residents were evaluated annually for evacuation time, using the Department's form (Resident 1, Resident 2 and Resident 3). Findings include: On 06/05/2026, at 11:15 a.m., Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 was admitted on 09/04/2024 with diagnoses including Type 2 diabetes mellitus, schizophrenia, and delusional disorders. Resident	M 346		

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M 346	Continued From page 7 1's record did not contain a fire evacuation evaluation form for 2025. Example 2: Resident 2 Resident 2 was admitted on 05/06/2023 with diagnoses including quadriplegia, Cerebral palsy, and severe intellectual disabilities. Resident 2's last fire evacuation evaluation was dated 05/10/2024. Resident 2's record did not contain a fire evacuation evaluation form for 2025. Example 3: Resident 3 Resident 3 was admitted on 06/15/2024 with diagnoses including functional quadriplegia, diabetes mellitus, seizures, and hypertension. Resident 3's last fire evacuation evaluation was dated 08/16/2024. Resident 3'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 them out and I forgot."	M 346		
M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure written documentation of	M 348		

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M 348	Continued From page 8 the date and the evacuation time for 2 of 2 drills were maintained. There were no recorded fire drills from 01/01/2025 through 12/31/2025. Findings include: On 06/05/2026, at 11:15 a.m., Surveyor requested 2025 semi-annual fire drills. Surveyor did not observe fire drills for 2025. On 06/05/2026, at approximately 12:35 p.m., Licensee A stated, "I really thought I did them. I don't know what happened. I do not have them."	M 348		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.	M 424		

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M 424	Continued From page 9	M 424		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the individual service plan (ISP) for 2 of 2 residents was reviewed at least once every 6 months. The provider did not ensure that a statement of agreement with the Individual Service Plan (ISP) was dated and signed by all individuals involved in developing the plan for 2 of 2 residents.

Findings include:

On 06/05/2026, Surveyor reviewed resident records and identified the following:

Example 1: Resident 1
Resident 1 was admitted on 09/04/2024 with diagnoses including type 2 diabetes mellitus, schizophrenia, and delusional disorders. Resident 1 was his/her own person. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Surveyor observed Resident 1's ISP was dated 04/13/2025. Resident 1's record did not include evidence Resident 1's ISP was reviewed and updated on 10/2025, or 04/2026. The ISP was not signed by the person completing the ISP, Resident 1 or Resident 1's managed care team.

Example 2: Resident 2
Resident 2 was admitted on 05/06/2023 with diagnoses including quadriplegia, cerebral palsy, and severe intellectual disabilities. Resident 2 had an activated health care power of attorney (AHCPOA). Resident 2 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Surveyor observed Resident 2's ISP was dated 05/06/2023. Resident 2's record did not include

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M 424	Continued From page 10 evidence Resident 2's ISP was reviewed and updated on 11/2023, 05/2024, 11/2023, 05/2024, 11/2025, or 05/2026. The ISP was not signed by the person completing the ISP, Resident 2's AHCPOA or Resident 2's managed care team. On 06/05/2026, at 4:23 p.m., Surveyor interviewed Licensee A who reported s/he was unaware of the requirement to review the ISP every 6 months with the residents and the care managers. Licensee A stated, "I thought I could just update them as changes occurred. I thought that what I did was okay."	M 424		
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 accurate records were kept of all prescription medications administered for 1 of 1 resident (Resident 1). Resident 1's May Medication Administration Record (MAR) was missing signatures from 05/01/2026 to 05/27/2026.	M 466		

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M 466	Continued From page 11 Findings include: On 06/05/2026, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted on 09/04/2024 with diagnoses including type 2 diabetes mellitus, schizophrenia, and delusional disorders. Resident 1 was his/her own person. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 1's Medication Administration Record (MAR), dated 05/01/2026 to 05/31/2026, documented: - The 8:00 a.m. quetiapine fumarate 200 milligram (mg) tablet was not signed out as given, available or refused 8 out of 15 times from 05/01/2026 to 05/15/2026. - The 4:00 p.m. quetiapine fumarate 200 mg tablet was not signed out as given, available or refused 11 out of 15 times from 05/01/2026 to 05/15/2026. - The 8:00 p.m. quetiapine fumarate 200 mg tablet was not signed out as given, available or refused 7 out of 15 times from 05/01/2026 to 05/15/2026. - The 5:00 p.m. quetiapine fumarate 200 mg tablet was not signed out as given, available or refused 2 out of 16 times from 05/16/2026 to 05/31/2026. - The 9:00 p.m. quetiapine fumarate 200 mg tablet was not signed out as given, available or refused 2 out of 16 times from 05/16/2026 to	M 466		

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M 466	Continued From page 12 05/31/2026. - The 8:00 a.m. vitamin D3 25 microgram (mcg) tablet was not signed out as given, available or refused 9 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 a.m. Jardiance 25 mg tablet was not signed out as given, available or refused 10 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 a.m. aripiprazole 30 mg tablet was not signed out as given, available or refused 9 out of 31 times from 05/01/2026 to 05/31/2026. - The 4:00 p.m. lithium carbonate 600 mg capsule was not signed out as given, available or refused 13 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 p.m. atorvastatin 40 mg tablet was not signed out as given, available or refused 10 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 a.m. vitamin B-1 100 mg. tablet was not signed out as given, available or refused 9 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 a.m. carvedilol 3.125 mg tablet was not signed out as given, available or refused 9 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 p.m. carvedilol 3.125 mg tablet was not signed out as given, available or refused 10 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 a.m. docusate sodium 100 mg tablet was not signed out as given, available or refused 9 out of 31 times from 05/01/2026 to 05/31/2026.	M 466		

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M 466	Continued From page 13 - The 8:00 a.m. Therems multi-vitamin tablet was not signed out as given, available or refused 9 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 a.m. clonazepam 0.5 mg tablet was not signed out as given, available or refused 9 out of 31 times from 05/01/2026 to 05/31/2026. - The 4:00 p.m. clonazepam 0.5 mg tablet was not signed out as given, available or refused 12 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 a.m. amlodipine besylate 5 mg tablet was not signed out as given, available or refused 9 out of 31 times from 05/01/2026 to 05/31/2026. - The 8:00 a.m. quetiapine fumarate 100 tablet was not signed out as given, available or refused 2 out of 16 times from 05/15/2026 to 05/31/2026. - The 12:00 p.m. quetiapine fumarate 100 tablet was not signed out as given, available or refused 3 out of 16 times from 05/15/2026 to 05/31/2026. On 06/05/2026 at 12:40 p.m., Surveyor interviewed House Lead (HL) B, who stated his/her morning shifts get so busy, s/he can forget to sign the medication out. HL B stated, "There is so much to do at once." HL B confirmed s/he had medication training. On 06/05/2026 at 1:20 p.m., Surveyor interviewed Licensee A regarding missing entries in Resident 1's MAR. Licensee A stated, "I gave the meds. We can see they are gone. I just lost track and did not sign them. We will work on this."	M 466		
M 570	88.10(3)(l) Safe Physical Environment	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018304	A. BUILDING: _____ B. WING _____	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY HOME HEALTH CARE	4471 NORTH 39TH STREET MILWAUKEE, WI 53209

(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 570	Continued From page 14 Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the home did not provide a safe physical environment. There were 20 boxes of adult briefs and disposable under pads stacked around and within five inches of the furnace. Findings include: On 06/05/2026 at 9:20 a.m., Surveyor toured the facility and observed the following: There were 20 boxes of adult briefs and disposable under pads stacked around and within inches of the furnace. On 06/05/2026 at 9:23 a.m., House Lead (HL) B confirmed that there were 20 boxes of adult briefs and disposable under pads stacked around and within inches of the furnace. On 06/05/2026 at 3:40 p.m., Surveyor discussed the listed topics with Licensee A and HL B. Manager A stated that s/he would take care of the items right away.	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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