STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015781	A. BUILDING: _____ B. WING _____	C 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANN CENTER FOR INTERGENERATIONAL CARE	2450 W NORTH AVE MILWAUKEE, WI 53205

(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
E 000	INITIAL COMMENTS An unannounced, onsite Recertification and Complaint survey was conducted on 02/24/2026 at St. Ann Center For Intergenerational Care in Milwaukee, WI in response to complaints #WI00062971 and #WI00062978. St. Ann Center For Intergenerational Care is out of compliance with Wisconsin Administrative Code DHS 105.14 regulations for Adult Day Care Centers. Complaints #WI00062971 and #WI00062978 are substantiated Citations are issued. Current census on day of survey: 82 14,291 useable square footage Maximum number of Participants based on square footage: 285 Number of Participants per certification: 200	E 000		
E 131	105.14(2)(L)3. REPORTING SERIOUS INJURY REQUIRING TREATMENT An ADCC shall send a written report to the department within 3 working days after any of the following occurs: 3. Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a participant. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report to the the state agency an incident that required emergency care for 1 of 1 participant (Participant #6) in a total of 2 incident	E 131		

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

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E 131	Continued From page 1 reports reviewed. Findings include: Review of facility policies did not reveal a policy that provided specific direction on how to complete a state report. A review of facility incident report dated 11/10/2025 revealed Participant #6 had a fall striking her head, an ambulance was called and the participant required emergency room treatment and hospitalization. There was no evidence the incident was reported to the Department of Health Services. During an interview on 02/24/2026 at 11:15 AM, when asked who is responsible for state reporting requirements, COO C stated she "is most responsible for state reports. Director D is still in training." During an interview on 02/24/2026 at 3:40 PM when asked about state reporting for incident reports, COO C stated, "I don't know why they didn't." COO C went on to say, "We would call family, care team in a case like the hospital, we should absolutely be contacting [state agency]."	E 131		
E 201	105.14(7)(b)2. SERVICE PLAN: REVIEW AT LEAST EVERY 6 MONTHS The service plan will be reviewed and revised every 6 months or when necessary due to changes in the participant's functioning, health condition, or preferences. Changes shall be documented in the participant's record.	E 201		

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E 201	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview the facility failed to review and revise as needed, participants' Individual Service Plan (ISP) every 6 months in 5 of 5 Participant files (Participants 1, 2, 3, 4, 5) reviewed. Findings: Review of the facility's "Adult Services Client Handbook 2025" revealed, "Individual Service Plan meetings: Bi-annual individual service plan meetings are held to evaluate each cleint's progress and needs." A review of Participant #1's record revealed a start of care date of 11/29/2023. There was no evidence of the ISP being updated every 6 months. A review of Participant #2's record revealed a start of care date of 09/08/2025. There was no evidence of the ISP being updated every 6 months. A review of Participant #3's record revealed a start of care date of 07/02/2024. There was no evidence of the ISP being updated every 6 months. A review of Participant #4's record revealed a start of care date of 06/02/2022. There was no evidence of the ISP being updated every 6 months. A review of Participant #5's record revealed a start of care date of 10/28/2013. There was no evidence of the ISP being updated every 6 months.	E 201		

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E 201	Continued From page 3 During an interview on 02/24/2026 at 4:15 PM Chief Operating Officer C confirmed there was no other evidence the facility has to show the ISP is reviewed and updated every 6 months or as needed.	E 201		
E 247	105.14(8)(e)1-7. DELAYED EGRESS LOCKS Delayed egress door locks are permitted with Department approval only in an ADCC with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: 1. No more than one device shall be present in a means of egress. 2. A sign shall be posted adjacent to the locking device indicating how the door may be opened. 3. The doors shall unlock upon activation of the sprinkler system or fire detection system. The doors shall unlock upon loss of power controlling the lock or locking mechanism. 4. The door locks shall have the capability of being unlocked by a signal from the ADCC's fire command center. 5. An irreversible process will occur which will release the latch in not more than 15 seconds when a force of no more than 15 pounds is applied for 3 seconds to the release device. Initiation of the irreversible process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, re-locking shall be by manual means only. 6. To obtain department approval for a delayed egress lock, the ADCC shall: a. Demonstrate the delayed egress lock is necessary to ensure the safety of every participant served by the ADCC, specifically persons at risk of elopement due to behavioral concerns, cognitive impairments or dementia, including Alzheimer's disease. b. Obtain	E 247		

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E 247	Continued From page 4 documentation from the local municipality that the delayed egress door lock system complies with the requirements under sub. (8), par. (e) of this section and applicable building codes. 7. Upon installation of the approved delayed egress lock system, the operator shall obtain documentation from the installer that the system has been installed, tested, and is fully operational as designed and approved. The ADCC shall submit the documentation to the department within 10 days of completion of the installation. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to obtain state department waiver for 2 of 2 locked delayed egress doors. Findings Include: During an observation on 2/24/2025 at 4:00 PM, the facility was found to have 2 egress doors accessible to ADCC participants. In an interview on 2/24/2026 at 4:00 PM, when asked about locked egress doors Director D stated to open the doors they need a badge or, the door release had to be pushed for 10 seconds and would release sounding an alarm. When asked if a waiver had been obtained for the egress door, Director D stated there was no waiver for the door.	E 247		
Z 001	Initial Comments An unannounced onsite Recertification and Complaint survey was conducted on 2/24/2026 at St. Ann Center for Intergenerational Care in	Z 001		

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Z 001	Continued From page 5 Milwaukee, WI in response to complaints #WI00062971 and #WI00062978. The agency is in compliance with regulations for Wisconsin Administrative Code DHS Chapters 12 and 13. A total of 5 personnel files were reviewed.	Z 001		
L 000	Initial Comments An unannounced onsite Recertification and Complaint survey was conducted on 2/24/2026 at St. Ann Center for Intergenerational Care in Milwaukee, WI in response to complaints #WI00062971 and #WI00062978. The facility is in compliance with the Federal Regulations 42 CFR 441.301 Home and Community Based Services benchmarks/requirements. No Citations issued.	L 000		