

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0020256</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/08/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ONE FAMILY ASSISTED LIVING</b> |                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1828 S 31ST ST</b><br><b>MILWAUKEE, WI 53215</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {N 000}                                                               | <p>Initial Comments</p> <p>On 07/08/2025, Surveyor completed a verification visit at One Family Assisted Living. Statement of Deficiency A6QW12 was corrected, and no new deficiencies were identified.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee will be assessed.</p> <p>Census: 10</p> | {N 000}                                                                                      |                                                                                                                          |                                                                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE