STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016815	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS OF FAMILY ADULT HOME	5322 N 73RD STREET 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 06/24/2026, Surveyor concluded an abbreviated survey at Friends of Family Adult Home. Three deficiencies were identified. Census: 3	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 1 of 2 staff reviewed (Caregiver C). Findings include: On 06/23/2026 at 10:35 a.m., Surveyor received	M 232		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016815	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS OF FAMILY ADULT HOME	5322 N 73RD STREET 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 232	Continued From page 1 employee roster from Lead Caregiver (LC) B. Surveyor observed Caregiver C's start date was 02/24/2021. On 06/23/2026 at 11:05 a.m., Surveyor reviewed Caregiver C's records and identified the following: Caregiver C was hired on 02/24/2021. Caregiver C started working with the residents in the home on 02/24/2021. Caregiver C was tested for TB on 03/22/2021; however, the provider did not obtain documentation from a physician, a registered nurse, or a physician's assistant indicating Caregiver C had been screened for illness detrimental to residents, as required. Caregiver C 's record did not contain a screening for communicable disease, and his/her TB test was almost 1 month overdue. On 06/23/2026 at 11:15 a.m., Surveyor interviewed LC B, who confirmed Caregiver C's hire date and start on the floor date were the same day. On 06/23/2026 at 11:15 a.m., Surveyor interviewed LC B, who confirmed Licensee A kept TB and communicable disease tests in overflow files. On 06/23/2026 at 1:05 p.m., Surveyor interviewed Licensee A, who stated s/he may have Caregiver C's communicable disease form in Caregiver C's overflow file. Licensee A acknowledged Caregiver C's TB test was obtained after his/her start of providing service. Licensee A confirmed being aware of the code requirement.	M 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016815	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS OF FAMILY ADULT HOME	5322 N 73RD STREET 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 276	Continued From page 2	M 276		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was well-maintained, and a homelike environment. The residents' bathroom required repairs. Under the brown painted kitchen cabinet handles, the paint was worn down to bare wood color. Resident 1's bedroom walls contained black scuff marks along the length of the room. Findings include: On 06/23/2026, Surveyor toured the home and observed the following: Kitchen: -The top of the table had paint chipped and peeled off on the surface. - Under the brown painted kitchen cabinet handles, the paint was worn down to bare wood color. Surveyor observed two cabinet doors above the microwave, three above and two below the medication refrigerator. Bathroom: -The bathroom had paint scrapes on the walls	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016815	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS OF FAMILY ADULT HOME	5322 N 73RD STREET 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 276	Continued From page 3	M 276		

behind the sink.
-The inside closet door was white with dark scrapes along the whole length of the door.
-The caulk trim around the corner of the floor at the bathtub, was peeling and contained areas that were stained dark brown/black, consistent with mold and mildew.
-Behind the sink, the wall was patched with what appeared to be spackle/paste uneven patterning.
-The light fixture, above the sink and mirror, held three light bulbs in a metal base. The metal base was reddish, brown in color, consistent with rust.
-Under the sink, where the water pipes went into the wall, there was a large cut hole around the pipes. Surveyor observed a rag hanging on the "U" shaped portion of the water pipes.

Hallways:

-The hallway was painted white. There were black scuff marks along the length of the hallway. The black scuff marks were prominently focused on the bottom and the middle of the walls and bedroom doors. The black scuff marks were consistent with the approximate size of a wheelchair scraping against the wall. There were also areas within the black scuff marks where the paint had been completely scraped off.
-Areas of black scrapes were observed on the door frames of 3 of 3 residents' bedrooms and 1 of 1 residents' bathroom.
-The vent next to the laundry room contained multiple spots of reddish, brown in color spots, consistent with rust.

Resident 1's Bedroom:

-Resident 1's wall and baseboards contained black scuff marks along the length of the room. The black scuff marks were prominently focused

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016815	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS OF FAMILY ADULT HOME	5322 N 73RD STREET 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 276	Continued From page 4 on the bottom and the middle of the walls and bedroom doors. The black scuff marks were consistent with the approximate size of a wheelchair or a mechanical lift, scraping against the wall. -Resident 1's window shade was extended half-way down the window and clipped with an office binder clip, to keep it open. -Behind Resident 1's headboard, Surveyor observed black scuff marks along the length of the wall, consistent with the height of the headboard. On 06/23/2026 at 10:57 a.m., Surveyor toured Resident 1's bedroom with Lead Caregiver (LC) B. Surveyor asked LC B to identify the black scuff marks along the baseboards, length of the wall and behind Resident 1's headboard. LC B stated the scuffs behind the bed were from Resident 1's old bed being moved back and forth and scraping his/her wall. S/He stated the black scuff marks along the baseboards and the length of the wall were from either Resident 1's wheelchair or the mechanical lift. LC B stated, "I don't know. Maybe the caregivers aren't paying attention and scraping the walls." Surveyor asked LC B about Resident 1's window shade that was extended half-way down the window and clipped with an office binder clip. LC B stated that the shade came in large, so they had to cut it. The shade did not spring up and down, so they just clipped it with a binder clip. On 06/23/2026 at 1:20 p.m., Surveyor interviewed Licensee A about the scuff marks in the hallways. Licensee A stated they realized the facility needed cosmetic attention and already had a contractor scheduled to come in and start working on repairs.	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016815	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS OF FAMILY ADULT HOME	5322 N 73RD STREET 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 276	Continued From page 5 On 06/23/2026 at 1:20 p.m., Surveyor interviewed Licensee A and LC B about the bathroom. LC B stated s/he kept the towel around the base of the plumbing for quick clean up. Licensee A confirmed the bathroom needed repairs and they intended to have the bathroom fixed soon.	M 276		
M 570	88.10(3)(l) Safe Physical Environment 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 was a 2 ¼ step leading into a laundry/furnace room, separated only by a curtain. The clothes dryer was not completely vented with rigid metal tubing. Findings include: On 09/12/2017, this facility was licensed to serve up to 4 nonambulatory residents with primary diagnoses of emotionally disturbed/mental illness, physically disabled, advanced aged, developmentally disabled, terminally ill,	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016815	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS OF FAMILY ADULT HOME	5322 N 73RD STREET 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 570	Continued From page 6 irreversible dementia/Alzheimer's, and traumatic brain injury. On 06/23/2026 at 9:45 a.m., Surveyor toured the facility and observed the following: The main hallway of the facility contained 3 bedrooms and one resident bathroom. At the end of the main hallway, to the right, Surveyor observed a laundry/furnace room that had a curtain that closed the room off from the residents. Surveyor observed a 2 ¼ inch step into the laundry/furnace room. To the left of the hallway, Surveyor observed a vacant resident bedroom. In the laundry/furnace room, Surveyor observed a flexible aluminum foil duct for dryer vent tubing. On 06/23/2026 at 10:05 a.m., Surveyor interviewed Lead Caregiver (LC) B, who stated residents do not ambulate down into the laundry/furnace room area. Surveyor asked LC B if s/he was aware of the providers' ambulation status. LC B stated, "I can see where that could be a safety concern. The curtain couldn't stop someone from falling off the step, into the laundry/furnace room." On 06/23/2026 at 10:10 a.m., Surveyor interviewed LC B, who stated the provider just purchase a new dryer at the beginning of the year and the store installed the dryer. LC B stated, "I inspected it when it was completed. It looked fine to me." On 06/23/2026 at 1:20 p.m., Surveyor interviewed Licensee A, who stated s/he was aware of the code requirements for dryer vent tubing.	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016815	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS OF FAMILY ADULT HOME	**5322 N 73RD STREET 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 570	Continued From page 7 On 06/24/2026 at approximately 9:35 p.m., Licensee A emailed photographs of the dryer tubing. Licensee A stated, "The contractor successfully installed the proper ventilation today."	M 570		