STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	**7848 N 55TH ST MILWAUKEE, WI 53223**

(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 04/17/2025 with information gathered through 05/06/2025, Surveyor conducted a standard survey and complaint investigation, at Grice Adult Family Home, an Adult Family Home (AFH) in Milwaukee, WI. Twenty-two deficiencies were identified. Complaint substantiated. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department, within 24 hours, when 1 of 1 resident (Resident 2) eloped and was reported missing. Resident 2 eloped from the facility and the provider did not report to the department. Findings include: On 04/17/2025, Surveyor reviewed Resident 2's	M 134		

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
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 134	Continued From page 1	M 134		

record and identified the following:

-Resident 2 was admitted to the provider's home on 09/01/2023.

-Resident 2 had a legal guardian.

On 04/22/2025, Surveyor reviewed Milwaukee Police Department (MPD) report for incident involving Resident 2 at the facility and identified the following:

Incident on 10/22/2023

-On 10/22/2023, MPD officers were dispatched to a missing person call at facility.

-Upon arrival MPD officers spoke to staff who stated that Resident 2 left the premises and have not returned. Staff stated that Resident 2 was last seen at 5:00 PM sitting on the porch.

-Resident 2 returned to the facility on the night of 10/22/2023.

On 04/22/2025, Surveyor completed a review of the Department facility folder. Surveyor did not observe any self-reports submitted to the Department in 2023.

On 04/17/2025, at approximately 8:58 AM, Surveyor called Licensee A via phone to inform him/her that Surveyor was onsite at facility. Licensee A did not answer his/her phone. Surveyor left Licensee A a voicemail with request for an immediate response.

On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B stated that s/he was not aware of this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 134	Continued From page 2 requirement. As of 05/06/2025, Surveyor did not receive a return phone call from Licensee A.	M 134		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees (Caregiver D) reviewed received training in standard precautions as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens, prior to providing care to residents and annually. Caregiver D did not receive training in standard precautions. The OSHA standard requires the employer train each employee with occupational exposure, "At the time of initial assignment to tasks where occupational exposure may take place" per 1910.1030(g) (2)(ii)(A); and "At least annually thereafter," per 1910.1030(g)(2)(ii) (B). Findings include:	M 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 235	Continued From page 3 On 04/17/2025, Surveyor reviewed Caregiver D's record and identified the following: -Caregiver D was hired on 02/18/2019. -Caregiver D's record did not contain documentation s/he received prior to providing care to residents. On 04/17/2025 at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed Caregiver D assisted Resident 1 with changing of his/her briefs. Supervisor B confirmed Caregiver D did not receive standard precautions training. Supervisor B stated that if Caregiver D received standard precautions training that documentation would be in his/her record.	M 235		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 service provider (Caregiver D) received training within 6 months	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 244	Continued From page 4 after starting to provide care related to health, safety and welfare of residents, resident rights and treatment appropriate to residents, fire safety and first aid. Findings include: On 04/17/2025, Surveyor reviewed Caregiver D's record and identified the following: -Caregiver D was hired on 02/18/2019. -Caregiver D's employee record did not contain evidence of training. On 04/17/2025 at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed Caregiver D did not have training related to health, safety and welfare of residents, resident rights and treatment appropriate to residents, fire safety and first aid within 6 months of hire. Supervisor B stated that if Caregiver D received above training that documentation would be in his/her record.	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received.	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 246	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each employee completed 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights, and treatment of residents for 2 of 2 service providers (Caregiver C and Caregiver D) who required annual training. Caregiver C and Caregiver D did not receive annual training in 2024. Findings include: On 04/17/2025, Surveyor reviewed caregiver records and identified the following: -Caregiver C was hired on 06/24/2018. Caregiver C's record did not contain evidence of him/her receiving annual training in 2024. -Caregiver D was hired on 02/18/2019. Caregiver D's record did not contain evidence of him/her receiving annual training in 2024. On 04/17/2025 at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed Caregiver C's and Caregiver D's records did not contain evidence of receiving annual training in 2024. Supervisor B stated if Caregiver C and Caregiver D received above training that documentation would be in his/her record.	M 246		
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	M 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 262	Continued From page 6	M 262		

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, record review, and interview, the provider did not ensure the ramps installed at 2 exits from the home were equipped with handrails. The provider also did not ensure all doorway clear openings were at least 32 inches for 1 of 1 bedroom. Resident 3 had difficulty walking and utilized a wheelchair for mobility.

Findings include:

On 04/17/2025, Surveyor reviewed Resident 3's record and identified the following:

-Resident 3 was admitted to the provider's home on 02/02/2025 with diagnoses of superficial frostbite of left foot, and superficial frostbite of right foot.

-Resident 3's Resident Evacuation Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 262	Continued From page 7 (RES), dated 02/02/2025, indicated Resident 3 was not physically able to start and complete an evacuation without physical assistance. Supervisor B was listed as the evaluator of the RES. On 04/17/2025, at approximately 5:00 PM, Surveyor conducted a tour of the facility with Supervisor B and observed the following: -The front exit ramp did not have handrails. -The rear exit ramp did not have handrails. -Resident 3 required the use of a wheelchair for mobility. -Resident 3's bedroom had a doorway with a clear opening of 30 inches. -Resident 3 demonstrated how s/he had a difficult time moving in and out of his/her bedroom. On 04/17/2025, at approximately 5:05 PM, Surveyor interviewed Resident 3. Resident 3 reported s/he had a difficult time getting his/her wheelchair through his/her bedroom door opening. Resident 3 reported the opening was very tight, and the hallway is narrow, so it makes it very difficult. On 04/17/2025, at approximately 5:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed the ramps did not have handrails. Supervisor B confirmed Resident 3 utilized a wheelchair for mobility. Supervisor B confirmed Resident 3 was not able to easily navigate in and out his/her bedroom.	M 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 8	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 a clean, well-maintained and homelike environment. The home required cleaning and/or repairs. This had the potential to affect 4 of 4 residents (Resident 1, Resident 2, Resident 3, and Resident 4) residing in the facility. Findings include: On 04/17/2025, at approximately 5:00 PM, Surveyor conducted a tour of the facility with Supervisor B and observed the following: -Stairs leading to basement were steep/cracked. -Door near basement staircase metal door threshold was bent. -Black corrosion on the top of the water heater and floor near water heater. -Lint was caked up behind dryer on basement floor/sticky rodent trap. -The kitchen flooring near back entrance door was cracked. -There was no electrical cover for the outlet in the kitchen. -Appearance of dirt build-up at back entrance	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 9 door. -Front entrance transition threshold strip had existing hump. -The back entrance ramp had missing vertical baluster spindles in sections throughout. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B about above concerns. Supervisor B confirmed the concerns and stated s/he would have the maintenance person address the issues.	M 276		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company. This Rule is not met as evidenced by: Based on record review and interview the facility did not ensure the gas furnace was inspected and serviced every 3 years by a heating contractor or local utility company for 1 of 1 furnace. Findings include: On 04/17/2025, Surveyor requested to review facility's most recent furnace inspection from Supervisor B. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B stated s/he would send the inspection report via email by 5:00 PM on 04/18/2025. As of 05/06/2025, Surveyor did not receive documentation of a furnace inspection for the home.	M 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 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 ensure 2 of 2 fire extinguishers were inspected annually by an authorized dealer or the local fire department. The fire extinguishers, located in the kitchen and basement, were last inspected March 2022. Findings include: On 04/17/2025, at approximately 5:00 PM, Surveyor toured the facility and observed the fire extinguishers in the kitchen and in the basement were dated March 2022.	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 332	Continued From page 11 On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B stated s/he did not have any knowledge regarding why the fire extinguishers were not inspected annually. Supervisor B confirmed the inspection tags read March 2022.	M 332		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in 2 of 6 required locations. There were no smoke detectors in Residents 1 and 4's shared bedroom and Resident 2's bedroom. Findings include: On 04/17/2025, at approximately 5:00 PM,	M 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 334	Continued From page 12 Surveyor conducted a tour of the facility with Supervisor B and observed the following: -Resident 1's and Resident 4's shared bedroom did not contain a smoke detector. -Resident 2's bedroom did not contain a smoke detector. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed the above mentioned locations did not have a smoke detector. Supervisor B stated S/he would have the maintenance person install a smoke detector in the bedrooms. CROSS REFERENCE M 0332 88.05(4)(a) Fire Safety-Fire Extinguishers M 0344 88.05(4)(d)2.a Fire Safety Evacuation Plan Review M 0346 88.05(4)(d)2.b Fire Evacuation Annual Evaluation	M 334		
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	M 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 336	Continued From page 13 provider did not ensure monthly smoke detector testing for 1 of 1 year (2024) reviewed. There was no evidence smoke detectors were checked in 2024. Findings include: On 04/17/2025, Surveyor requested to review monthly smoke detector testing for 2024 from Supervisor B. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B stated S/he would send the monthly smoke detector testing for 2024 via email by 5:00 PM on 04/18/2025. As of 05/06/2025, Surveyor did not receive documentation of the monthly smoke detector testing for 2024.	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 record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 2) reviewed was evaluated annually for evacuation time, using the Department's form. Resident 1 had not been	M 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 346	Continued From page 14	M 346		

evaluated for evacuation for calendar years 2023 and 2024 using the Department's form. Resident 2 had not been evaluated for evacuation for calendar year 2024 using the Department's form.

Findings include:

The facility is licensed to provide services for up to 4 residents with client groups of advanced aged, emotionally disturbed/mental illness, developmentally disabled, and irreversible dementia/Alzheimer's.

On 04/17/2025, Surveyor reviewed Resident 1's record. Resident 1's record indicated the following:

-Resident 1 was admitted to the provider's home on 08/29/2022. Resident 1's record did not contain evidence of an evacuation assessment for calendar years 2023 and 2024 using the Department's form.

On 04/17/2025, Surveyor reviewed Resident 2's record. Resident 2's record indicated the following:

-Resident 2 was admitted to the provider's home on 09/01/2023. Resident 2's record did not contain evidence of an evacuation assessment for calendar year 2024 using the Department's form

On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B stated s/he was not aware of this requirement to complete the evacuation assessments annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 348	Continued From page 15	M 348		
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 maintain a record of semi-annual fire drills conducted with all household members for 1 of 1 year (2024). The provider had no fire drills completed for calendar year 2024. Findings include: On 04/17/2025, Surveyor requested to review fire drills for calendar year 2024 from Supervisor B. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B about fire drills. Supervisor B stated s/he would send fire drills for calendar year 2024 via email by 5:00 PM on 04/18/2025. As of 05/06/2025, Surveyor did not receive evidence of semi-annual fire drills for calendar year 2024.	M 348		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need.	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 412	Continued From page 16	M 412		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not have a description of the services in the individual service plan (ISP) the licensee would provide to meet the assessed needs of 1 of 1 resident (Resident 3). Resident 3 had a history of ambulatory problems. Resident 3's ISP did not address Resident 3's utilization of a wheelchair to ambulate.

Findings include:

On 04/17/2025, Surveyor reviewed Resident 3's record and identified the following:

-Resident 3 was admitted to the provider's home on 02/02/2025 with diagnoses of superficial frostbite of left foot, and superficial frostbite of right foot.

-Resident 3 was his/her own person.

-Resident 3's My Choice Wisconsin Member Centered Plan (MCP) was dated 02/01/2025. Resident 3's MCP stated the following:

-"Member will maintain safety when completing activities of daily living and instrumental activities of daily living with assistance. Member had all of [his/her] toes amputated plus additional surgeries due to frostbite and is still healing and recovering. Member is currently non-weight bearing."

-"Mobility (In the Home): Level of assistance - Independent (Member Strength). Durable Medical Equipment - Wheelchair or Scooter; Walker."

-"Mobility (Outside the Home): Level of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 412	Continued From page 17 assistance - Needs Assistance. Durable Medical Equipment - Wheelchair or Scooter." -Resident 3's comprehensive pre-admission health assessment was dated 02/02/2025. Resident 3's comprehensive pre-admission health assessment stated the following: -Assistive devices: "Wheelchair." -Mobility: "Resident 3 requires occasional assistance" -Resident 3's ISP was dated 02/02/2025. Resident 3's ISP did not describe his/her mobility needs. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B reported s/he and Licensee A was responsible for the creation of ISPs. Supervisor B confirmed Resident 3's ISP did not reflect the above information. Supervisor B stated Resident 3 utilized a wheelchair to ambulate in the home and outside the home. Supervisor B stated moving forward s/he would ensure Resident 3's ISP addressed his/her ambulatory problems and utilization of a wheelchair.	M 412		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by:	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 420	Continued From page 18 Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 3) individual service plans (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 1's and Resident 3's ISPs did not include a signed statement of agreement with all parties involved. Findings include: On 04/17/2025, Surveyor reviewed Resident 1's record and identified the following: - Resident 1 was admitted to the provider's home on 08/29/2022. - Resident 1 had a power of attorney. - The consumer roster identified Resident 1 had a managed care organization (MCO) case management team. - Surveyor reviewed Resident 1's ISPs dated 10/03/2022, 04/03/2023, and 11/03/2023. Resident 1's ISPs did not contain a power of attorney signature or MCO case management team signatures. On 04/17/2025, Surveyor reviewed Resident 3's record and identified the following: - Resident 3 was admitted to the provider's home on 02/02/2025. - Resident 3 was his/her own person. - The consumer roster identified Resident 3 had a managed care organization (MCO) case management team. - Surveyor reviewed Resident 3's ISP dated 02/02/2025. Resident 3's ISP did not contain Resident 3's signature or MCO case management team signatures.	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 420	Continued From page 19 On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed residents' ISPs needed to be signed by all parties in agreement with the plan. Supervisor B stated moving forward s/he would ensure all ISPs were signed by all parties.	M 420		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 2) reviewed had their individual service plan (ISP) reviewed every 6 months to determine continued appropriateness of the plan and to update the plan as necessary. Findings include:	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 424	Continued From page 20 On 04/17/2025, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 08/29/2022. -Resident 1 had a power of attorney. -Resident 1's ISP was dated 11/03/2023. There was no evidence Resident 1's ISP was reviewed and updated after 11/03/2023. At minimum, Resident 1's ISP should have been reviewed and updated in May 2024 and November 2024. On 04/17/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 09/01/2023. -Resident 2 had a corporate guardian. -Resident 2's record did not contain an ISP. Resident 2 was due for an ISP by 10/01/2023, 04/2024, 10/2024, and 04/2025. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B reported s/he was the one who completed the ISP updates. Supervisor B confirmed Resident 1's and Resident 2's ISP should have been reviewed at least once every 6 months to determine continued appropriateness of the plan and to update the plan as necessary. Supervisor B stated s/he did not know why Resident 2 did not have an ISP completed. Supervisor B stated moving forward s/he would ensure residents ISP were reviewed at least once every 6 months to determine continued appropriateness of the plan and to update the plan as necessary.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 448	Continued From page 21	M 448		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not monitor 2 of 2 residents' (Resident 1's and Resident 3's) health by observing and documenting changes in resident health and referring a resident to health care providers when necessary. Resident 3's bilateral feet wounds were not monitored by observing and documenting changes in his/her bilateral feet wounds. Resident 3 had frostbite to his/her feet. The provider did not monitor changes and Resident 3 ended up in the hospital being treated for infection twice. Resident 1's blood sugar was not monitored by observing and documenting changes in his/her blood sugar. The provider did not test Resident 1's blood sugar as ordered. Several consecutive months of blood sugar testing was not completed daily as ordered by his/her physician. Findings include: Example 1-Resident 3 On 04/17/2025, Surveyor reviewed Resident 3's record and identified the following: -Resident 3 was admitted to the provider's home on 02/02/2025 with diagnoses of superficial	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 448	Continued From page 22	M 448		

frostbite of left foot, and superficial frostbite of right foot.

-Resident 3's Individual Service Plan (ISP), dated 02/02/2025, stated the following: "[Resident 3] need help with [his/her] feet because [his/her] toes on both feet were amputated, only until they heal. [Resident 3] needs help with foot care."

-Resident 3's hospital After Visit Summary (AVS), dated 02/06/2025, stated the following: "Instructions: Wash bilateral feet with unscented soap and rinse daily. Apply silver sulfadiazine cream to gauze and then place on bilateral feet wounds. Wrap with kerlix (white gauze) and then ACE."

-Resident 3's AVS, dated 02/13/2025, stated the following: "Instructions: Wash wound daily with mild soap and water, use a vashe soak for 15 minutes on open areas. Use fine mesh gauze and silvadene cream over open areas of heels and front of foot then secure with kerlix wrap and tubigrip."

-Resident 3's AVS, dated 02/25/2025, stated the following: "Instructions: Ambulatory referral to home health. Registered Nurse for daily would care to bilateral feet. Wash feet with soap and H20, rinse with hypochlorous acid solution (Vashe) for 15 minutes then apply silvadene cream on fine mesh gauze and secure with kerlix roll and ace wraps on each foot. Physical therapy evaluation and treat. Please evaluate [Resident 3] for admission to Home Health."

-Resident 3's hospital discharge summary, dated 03/14/2025, stated the following: "Hospital Course: [Resident 3] was admitted on 03/05/2025 from clinic for frostbite to bilateral feet. Was living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 448	Continued From page 23	M 448		

in group [home] but ran out of bandages, feet became infected - prerequire to debride wounds and place in dermal substitutes, anticipating grafting down the line."

-Resident 3's hospital discharge summary, dated 04/08/2025, following: "Hospital Course: [Resident 3] was admitted on 03/26/2025 for grafting to bilateral feet following delamination of Biodegradable Temporizing Matrix. [Resident 3] will require the use of a wheelchair at discharge in order to get around and function/perform activities of daily living without walking - it's important that [Resident 3] not walk to allow these grafts to fully heal, to prevent infection/recurrent breakdown of wounds...Instructions: Daily wound cares, Wash with soap and water, Apply xeroform to open areas, Wrap in vashe moistened kerlix, Clean socks to secure, and non weight bearing."

On 04/17/2025, at approximately 6:00 PM, Surveyor interviewed Supervisor B regarding Resident 3 receiving wound care to bilateral feet. Supervisor B stated Resident 3 had not received wound care from facility staff. Supervisor B stated s/he was not aware that Resident 3 required wound care. Supervisor B stated s/he was not aware Resident 3 had a referral for a Registered Nurse to come to facility to provide daily would care to bilateral feet. Supervisor B confirmed Resident 3 did not have any home healthcare established to assist with caring for his/her feet after getting frostbite.

Example 2- Resident 1

On 04/17/2025, Surveyor reviewed Resident 1's record and identified the following:

-Resident 1 was admitted to the provider's home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 448	Continued From page 24 on 08/29/2022 with diagnosis of diabetes. -Resident 1's ISP, dated 11/03/2023, did not contain any information regarding Resident 1's diabetes/blood sugar monitoring. -Resident 1's record included physician orders, dated 01/23/2024, to check Resident 1's blood sugar (BS) once daily. -Resident 1's Blood Sugar Log, dated 01/23/2024 through 04/16/2024, identified no readings on the following days: 01/23/2024-03/12/2024, 03/16/2024-03/17/2024, 03/24/2024, 03/26/2024-03/27/2024, 04/02/2024-04/03/2024, 04/06/2024-04/07/2024, 04/09/2024-04/11/2024, 04/13/2024-04/30/2024, 05/04/2024-05/31/2024, 06/01/2024-06/30/2024, 07/01/2024-07/31/2024, 08/01/2024-08/31/2024, 09/01/2024-09/30/2024, 10/01/2024-10/31/2024, 11/01/2024-11/30/2024, 12/01/2024-12/31/2024, 01/01/2025-01/31/2025, 02/01/2025-02/28/2025, 03/01/2025-03/31/2025, and 04/01/2025-04/16/2025. -Resident 1's blood sugar was not monitored once daily as ordered and missed for several consecutive month since the order was written. On 04/17/2025, at approximately 11:37 AM, Surveyor interviewed Supervisor B. Supervisor B stated that s/he was not aware Resident 1 had diabetes. Supervisor B stated s/he was not aware Resident 1's blood sugar needed to be checked. On 04/17/2025, at approximately 11:38 AM, Surveyor interviewed Caregiver D. Caregiver D stated s/he had never tested Resident 1's blood sugar. Caregiver D stated s/he was not aware that Resident 1's blood sugar needed to be checked.	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 448	Continued From page 25 On 04/17/2025, at approximately 11:39 AM, Surveyor interviewed Caregiver C. Caregiver C stated s/he had never tested Resident 1's blood sugar and did not know that Resident 1's blood sugar needed to be checked. On 04/17/2025, at approximately 11:55 AM, Surveyor observed the locked medication cabinet. Inside the locked medication cabinet contained Resident 1's medication on shelf. Resident 1's medication shelf contained the following: -2 Freestyle Lite Blood Glucose Test Strips 100 count unopened boxes. -Easy Comfort Lancets 30-gauge 100 count unopened box. -Resident 1's medication shelf did not contain a glucose meter.	M 448		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file.	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 464	Continued From page 26 This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician specifying who by name or position could administer medications for 2 of 2 residents (Resident 2 and Resident 3) reviewed who required staff to administer his/her medications. Resident 2 and Resident 3 did not have a written order permitting the provider staff to administer medications. Findings include: On 04/17/2025, Surveyor reviewed resident records. The following was identified: -Resident 2 was admitted to the provider's home on 09/01/2023. Resident 2's record did not have an order specifying who by name or position could administer his/her medication. -Resident 3 was admitted to the provider's home on 02/02/2025. Resident 3's record did not have an order specifying who by name or position could administer his/her medication. On 04/17/2025 at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed Resident 2 and Resident 3 required staff to administer their medication. Supervisor B confirmed Resident 2's and Resident 3's records did not contain evidence of a written order permitting the provider staff to administer medications.	M 464		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 466	Continued From page 27	M 466		

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 an accurate record of medication administration for 2 of 2 residents (Resident 1 and Resident 2). The Medication Administration Records (MARs) for Resident 1 contained omissions in January 2025, February 2025, March 2025, and April 2025. The Medication Administration Records (MARs) for Resident 2 contained omissions in April 2025.

Findings include:

On 04/17/2025, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the provider's home on 08/29/2022. Surveyors reviewed Resident 1's MAR for the months of January 2025, February 2025, March 2025, and April 2025. The following entries in Resident 1's MARs were blank:

8:00 AM:
-Gabapentin 100 milligrams (mg) capsule by mouth 3 times daily - 01/30/2025, 03/02/2025, 03/16/2025, 03/30/2025, and 04/12/2025-04/13/2025.
-Hydroxyzine hydrochloric acid (HCL) 25 mg tablet by mouth twice daily - 01/30/2025,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 466	Continued From page 28 03/02/2025, 03/16/2025, 03/30/2025, and 04/12/2025-04/13/2025. -Budesonide/formoterol inhaler inhale 2 puffs by mouth daily - 01/30/2025, 02/04/2025-02/05/2025, 02/07/2025, 02/10/2025-02/14/2025, 02/18/2025-02/27/2025, 03/16/2025, 03/27/2025, 03/30/2025-03/31/2025, and 04/09/2025-04/11/2025. -Carvedilol 6.25 mg tablet by mouth twice daily - 01/30/2025, 02/19/2025, 03/16/2025, 03/30/2025-03/31/2025, and 04/13/2025. -Eliquis 5 mg tablet by mouth twice daily - 01/30/2025, 02/19/2025, 03/16/2025, 03/23/2025, 03/30/2025-03/31/2025, and 04/13/2025. -Stool softener-laxative two tablets by mouth daily - 01/30/2025, 02/05/2025-02/07/2025, 03/02/2025, 03/16/2025, 03/30/2025, and 04/12/2025-04/13/2025. -Vitamin B12 1000 microgram tablet by mouth daily - 01/30/2025, 02/05/2025-02/07/2025, 03/02/2025, 03/16/2025, 03/21/2025, 03/30/2025-03/31/2025, and 04/12/2025-04/13/2025. 2:00 PM: -Gabapentin 100 milligrams (mg) capsule by mouth 3 times daily - 01/30/2025-02/27/2025, 03/01/2025-03/31/2025, and 04/01/2025-04/16/2025. 8:00 PM: -Gabapentin 100 mg capsule by mouth 3 times daily - 01/30/2025, 02/01/2025-02/02/2025, 02/05/2025, 02/11/2025, 02/15/2025-02/16/2025, 02/21/2025, 03/01/2025-03/02/2025, 03/04/2025, 03/06/2025-03/07/2025, 03/15/2025, 03/26/2025, 03/30/2025-03/31/2025, and 04/02/2025 . -Hydroxyzine HCL 25 mg tablet by mouth twice daily - 01/30/2025, 02/01/2025-02/02/2025, 02/05/2025, 02/09/2025, 02/11/2025,	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 466	Continued From page 29 02/15/2025-02/16/2025, 03/01/2025-03/02/2025, 03/04/2025, 03/06/2025-03/07/2025, 03/15/2025, and 03/30/2025-03/31/2025. -Risperidone 1 mg tablet by mouth at bedtime - 01/30/2025-02/11/2025, 02/13/2025-02/16/2025, 03/01/2025-03/02/2025, 03/04/2025-03/07/2025, and 03/30/2025-03/31/2025. -Simvastatin 20 mg tablet by mouth at bedtime - 01/30/2025-02/11/2025, 02/13/2025-02/16/2025, 03/01/2025-03/02/2025, 03/04/2025-03/07/2025, and 03/30/2025-03/31/2025. -Budesonide/formoterol inhaler inhale 2 puffs by mouth daily - 01/30/2025, 02/01/2025-02/02/2025, 02/05/2025, 02/11/2025-02/12/2025, 02/15/2025-02/16/2025, 02/19/2025, 02/22/2025-02/23/2025, 02/25/2025, 03/01/2025-03/02/2025, 03/06/2025-03/07/2025, and 03/30/2025-03/31/2025. -Carvedilol 6.25 mg tablet by mouth twice daily - 01/30/2025, 02/01/2025-02/02/2025, 02/05/2025, 02/11/2025, 02/15/2025-02/16/2025, 02/19/2025, 02/21/2025, 03/01/2025-03/02/2025, 03/04/2025, 03/06/2025-03/07/2025, and 03/30/2025-03/31/2025. -Donepezil HCL 5 mg tablet by mouth at bedtime - 01/30/2025, 02/01/2025-02/02/2025, 02/05/2025, 02/11/2025, 02/15/2025-02/16/2025, 02/19/2025, 03/01/2025-03/02/2025, 03/04/2025-03/07/2025, 03/23/2025, and 03/30/2025-03/31/2025. -Eliquis 5 mg tablet by mouth twice daily -01/30/2025, 02/01/2025-02/02/2025, 02/05/2025, 02/11/2025, 02/15/2025-02/16/2025, 02/19/2025, 03/01/2025-03/02/2025, 03/04/2025, 03/06/2025-03/07/2025, 03/23/2025, and 03/30/2025-03/31/2025. -Trazodone 50 mg tablet by mouth at bedtime - 01/30/2025, 02/01/2025-02/02/2025, 02/05/2025-02/07/2025, 02/11/2025, 02/15/2025-02/16/2025, 04/02/2025-04/04/2025,	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 466	Continued From page 30 and 04/12/2025. On 04/17/2025, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted to the provider's home on 09/01/2023. Surveyors reviewed Resident 2's MAR for the month of April 2025. The following entries in Resident 2's MARs were blank: 8:00 AM: -Risperidone 1 mg/milliliter (ml) two ml by mouth every morning and take two ml by mouth every evening - 04/02/2025-04/05/2025, 04/07/2025-04/13/2025, and 04/16/2025. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed Resident 1 and Resident 2 required assistance with medication administration for all of their medications listed. Supervisor B confirmed the MARs should have been documented accurately. Supervisor B stated the medications were given and staff did not document that medications were given.	M 466		
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	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 31 because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard residents from environmental hazards. The provider's water temperature was not kept at a safe temperature. The hot water in the shared bathroom 4 of 4 residents used measured 130.5° F. Findings include: The facility is licensed to provide services for up to 4 residents with client groups of advanced aged, emotionally disturbed/mental illness, developmentally disabled, and irreversible dementia/Alzheimer's. On 04/17/2025, at approximately 5:00 PM, Surveyor toured the facility and tested the water temperature in the main floor bathroom, used by 4 of 4 residents. The water temperature reached 130.5° F. On 04/17/2025, at approximately 7:00 PM, Surveyor interviewed Supervisor B regarding the temperature of the water. Supervisor B confirmed that the water temperature in the main floor bathroom reached 130.5° F. Supervisor B stated s/he would have the maintenance person adjust water temperature. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 32 dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (Source: Publication DHS P-01942 - 08/2017).	M 570		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure each resident received all prescribed medications in the dosage and at the intervals prescribed by the residents physician for 2 of 2 residents (Resident 1 and Resident 2) reviewed. Resident 1 had a total of 16 medications not administered between 04/15/2025 and 04/16/2025. Resident 2 had a total of 16 medications not administered between 04/01/2025 and 04/16/2025. Findings include: On 04/17/2025, at approximately 11:55 AM,	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 582	Continued From page 33 Surveyor observed the locked medication cabinet. Inside the locked medication cabinet contained Resident 1's medication on shelf. Surveyor observed Resident 1's medications were in dose packaging. Resident 1's medication shelf contained Resident 1's medication for the following past dates: -Carvedilol 6.25 milligrams (mg) tablet was not administered on 04/15/2025-04/16/2025 (A total of 2 doses). -Donepezil hydrochloric acid (HCL) 5 mg tablet was not administered on 04/15/2025-04/16/2025 (A total of 2 doses). -Eliquis 5 mg tablet was not administered on 04/15/2025-04/16/2025 (A total of 2 doses). -Gabapentin 100 mg capsule was not administered on 04/15/2025-04/16/2025 (A total of 2 doses). -Hydroxyzine HCL 25 mg tablet was not administered on 04/15/2025-04/16/2025 (A total of 2 doses). -Risperidone 1 mg tablet was not administered on 04/15/2025-04/16/2025 (A total of 2 doses). -Simvastatin 20 mg tablet was not administered on 04/15/2025-04/16/2025 (A total of 2 doses). -Trazodone 50 mg tablet was not administered on 04/15/2025-04/16/2025 (A total of 2 doses). Resident 1 had a total of 16 medications not administered between 04/15/2025 and 04/16/2025. On 04/17/2025, Surveyor reviewed Resident 2's Medication Administration Records (MARs) and identified the following: Resident 2's April 2025 MAR stated Resident 2 was prescribed the following medication:	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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 582	Continued From page 34 -Risperidone 1 mg/milliliter (ml) two ml by mouth every morning and take two ml by mouth every evening. -Risperidone 1 mg/milliliter two ml was not administered on 04/01/2025-04/16/2025 (A total of 16 doses). There was no place on MAR for staff to document 2nd dose of risperidone. Resident 2 had a total of 16 medications not administered between 04/01/2025 and 04/16/2025. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B stated Resident 1 and Resident 2 required staff to administer medications. Supervisor B confirmed Resident 1 and Resident 2 did not received their medication. Supervisor B stated s/he did not know why staff did not give medications. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed since there was not a place on Resident 2's MAR for staff to document the 2nd dose of risperidone staff was not aware Resident 1 required a second dose. Cross Reference M 0466 88.07(3)(e)1 Medication - Record Keeping	M 582		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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
Z 010	Continued From page 35 not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure every reasonable effort was made to contact the clerk of courts to obtain a copy of the complaint and judgement of conviction related to a conviction of s. 940.20(1) Battery by Prisoners, for 1 of 1 caregiver	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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
Z 010	Continued From page 36 (Caregiver D). Findings include: On 04/17/2025, at approximately 7:18 PM, Surveyor reviewed Caregiver D's record and identified the following: -Caregiver D was hired on 02/18/2019. -Caregiver D's Background Information Disclosure (BID) was completed and signed by him/her on 02/19/2019. -Caregiver D's Department of Justice (DOJ) record was requested and reported on 02/17/2019 and the following was identified: -"Date of offense: 03/26/2016... Charge: 940.20(1) - Battery by Prisoners... Disposition date: 09/23/2016. Disposition: Convicted... Sentencing date: 09/23/2016... Sequence number: 02... Sentence: Extended Supervision... Length: 18 months." -Caregiver D's Caregiver Background Check (IBIS) record was requested and reported on 02/17/2019 and the following was identified: -No findings. -No denials. -No exclusions. -No rehabilitation review findings. -No professional credential, license or certificate found. -Caregiver D's record did not include a copy of the complaint and judgement of conviction from the clerk of courts for the charge indicated on Caregiver D's background check.	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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
Z 010	Continued From page 37 On 04/17/2025, at approximately 8:58 AM, Surveyor called Licensee A via phone to inform him/her that Surveyor was onsite at facility. Licensee A did not answer his/her phone. Surveyor left Licensee A a voicemail with request for an immediate response. On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B stated that Licensee A is the one who completed background checks on staff and that s/he was not aware of Caregiver D's record. As of 05/06/2025, Surveyor did not receive a return phone call from Licensee A.	Z 010		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete caregiver background check (CBC) was completed every 4	Z 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	7848 N 55TH ST MILWAUKEE, WI 53223

(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
Z 022	Continued From page 38	Z 022		

years for 1 of 1 caregiver (Caregiver D) reviewed. Caregiver D's 4 year background check was due in February of 2023 and was not completed.

Findings include:

The provider is licensed to care for up to 4 residents within the following client groups: emotionally disturbed/mental illness, developmentally disturbed, irreversible dementia/Alzheimer's, and advanced aged.

On 04/17/2025, Surveyor reviewed Caregiver D's record and identified the following:

-Caregiver D was hired on 02/18/2019.

-Caregiver D's background check at hire was completed on 02/17/2019.

-Caregiver D's record did not contain any of the three necessary parts of the four-year background check due February of 2023.

On 04/17/2025, at approximately 8:58 AM, Surveyor called Licensee A via phone to inform him/her that Surveyor was onsite at facility. Licensee A did not answer his/her phone. Surveyor left Licensee A a voicemail with request for an immediate response.

On 04/17/2025, at approximately 7:30 PM, Surveyor interviewed Supervisor B. Supervisor B confirmed Caregiver D's record did not contain any of the three necessary parts of the four-year background check. Supervisor B stated that Licensee A is the one who completed background checks on staff.

As of 05/06/2025, Surveyor did not receive a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013601	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRICE ADULT FAMILY HOME	**7848 N 55TH ST MILWAUKEE, WI 53223**

(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
Z 022	Continued From page 39 return phone call from Licensee A.	Z 022		