STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015282	A. BUILDING: _____ B. WING _____	R-C 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE ADULT FAMILY HOME LLC	6441 N 71ST STREET MILWAUKEE, WI 53225

(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 01/07/2026, Surveyors conducted a complaint investigation, abbreviated survey, and 2 verification visits for Statements of Deficiency (SOD) QUC011 and SOD 352317 at Alliance Adult Family Home LLC. One of 1 complaint was unsubstantiated. Five deficiencies were identified. Three of the 5 deficiencies were repeat violations (see SOD 352313, SOD 352314, SOD 352315, SOD 352316, SOD 352317, and SOD QUC011). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
{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 adult family home (AFH) was safe, clean, well-maintained, and provided a homelike environment. The home required cleaning and repairs. This had the potential to affect 3 of 3 residents in the home.	{M 276}		

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

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{M 276}	Continued From page 1 This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) 352313, dated 03/26/2020; SOD 352314, dated 12/04/2020; and SOD 352317, dated 05/15/2023. Findings include: The facility was licensed as an ambulatory/non-ambulatory home, serving up to 3 residents in the client groups advanced age, physically disabled, traumatic brain injury, public funding, developmentally disabled, and emotionally disturbed/mental illness. On 01/07/2026, at 9:20 AM, Surveyor conducted an onsite tour of the home and observed the following: Exterior/Exits - The front ramp contained anti-slip strips, which were lifted, causing a trip hazard. - The front and back storm doors were not screened and did not contain glass. Living Room - A chair, with pink and gray floral print, was covered with a chux pad and had two pieces of decorative material, which were soiled, covering the armrests. Underneath the decorative material the armrests were torn which exposed the inner materials of the chair. - The curtain rod brackets were missing screws and hanging down from the wall. - Between the living area and the dining room was a half wall, which had a hole/breakage to the	{M 276}		

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{M 276}	Continued From page 2 drywall, approximately 3 inches in diameter. - The flooring was 1 square foot carpet squares and there were areas where the carpet was lifting. Kitchen - Above the window was an area of the wall/ceiling which was exposing the drywall and was water damaged. The brick face on the wall above this area was cracked. - The stove hood had a layer of a dust-like substance. - The microwave's interior protective enamel was peeling, which exposed the rusted metal frame. - A countertop microwave oven's interior was covered with a black substance and the interior window of the door had a greasy brownish film, consistent with food grease and splatter. - The dining table was a plastic folding table, approximately 2 feet by 5 feet, with 3 metal folding chairs and 1 padded folding chair. The table had grayish smear marks and white spots, from an unknown substance. The padded folding chair was torn at the backrest, which exposed the foam inside. - The cabinet under the sink had a padlock, which was unsecured, and contained cleaning compounds, including 3 containers of Comet with bleach, 1 bottle of Clorox disinfecting all-purpose cleaner, 1 bottle of glass cleaner, 1 bottle of Easy-Off cleaner degreaser, 1 bottle of Clorox toilet bowl cleaner with bleach, 1 bottle of cleaner with bleach, 1 bottle of all-purpose concentrated	{M 276}		

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{M 276}	Continued From page 3 cleaner, 2 bottles of Fabuloso multi-purpose cleaner, 1 bottle of carpet shampoo, 1 bottle of Oxi Clean with bleach, 1 bottle of orange glo wood furniture polish, 1 bottle of Scrubbing Bubbles bathroom grime fighter, and 1 can of Raid defense. Bathroom - A paper towel holder on the wall was absent of paper towel and only contained the cardboard tube. No other towels were present. - The ceiling fan had a layer of a grayish substance, consistent with dust. - The shower curtain rod was dented and bent inward. - A used, wet, balled up wash cloth was on a shower chair inside the shower, along with an open bar of soap. - The outer lip of the shower floor had caulk peeling away and loose. - An open bar of soap was on the floor of the shower. - The shower drain was covered with hair and a paper wrapper. - A pipe inside the wall of the shower was exposed and the tile around it was not sealed to keep water from going inside the wall. - The cap on a tube of toothpaste was covered in toothpaste and the tube was on the top of the toilet tank.	{M 276}		

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{M 276}	Continued From page 4 Resident 5's Room - A space heater was stored in the room. - A large chunk of dirt, which appeared to have come loose from footwear, was on the floor of the bedroom. - The drywall was chipped in several areas by the small cutout corner of the room. The drywall also contained a crack, approximately 6 inches in length. - Beyond the door, approximately 3 feet up the wall, was a black scuff mark which was approximately 3 feet in length and approximately 1 inch high. - One window was covered with plastic and inside of the window was filled with dust, debris, and cobwebs. - A second window contained 2 screens pushed together, which did not fit the window and was not fully covering the opening. - The door frame was missing the baseboard, which exposed the drywall. Resident 1's Room - The door was painted white and had black/brown/gray markings across the outside. - The carpet from the hallway, leading out of the bedroom was peeled up, causing a trip hazard. - Inside the entrance to the room, a brownish dried liquid was splattered on the wall and cork board hanging on the wall.	{M 276}		

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{M 276}	Continued From page 5 - Resident 1's pillow did not have a cover and was shredded in several places, which exposed the fill of the pillow. - The light switch and the wall around it were covered in black/brown/gray markings. On 01/07/2026, at 9:22 AM, Surveyors interviewed Caregiver H, and the following was reported: The cabinet under the kitchen sink was kept locked, but s/he had just finished cleaning and left it unlocked while accessing the cleaning products. On 01/07/2026, at 9:40 AM, Surveyors interviewed House Manager (HM) G, and the following was reported: The home had an issue with a leak in the roof. Ice was built up and when it melted it leaked in causing the issue with the ceiling area inside the kitchen. HM G was waiting for her/his roofing contractor to come out and fix the roof before s/he could make the repairs to the interior. On 01/07/2026, at approximately 10:15 AM, Surveyors toured the home with HM G and conducted an interview throughout the tour. The following was reported: Resident 1's pillow is typically covered with a pillowcase and HM G was unaware it was not. S/He reported the pillow was likely in "tattered condition" due to one of Resident 1's "tantrums." HM G acknowledged the dirt on Resident 1's bedroom door and walls, as well as the splattering and reported s/he would clean it. HM	{M 276}		

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{M 276}	Continued From page 6 G reported Resident 5's room had the space heater stored in it from when the heat went out in the home approximately 2 weeks ago. HM G acknowledged the plastic covered window and other window in Resident 5's bedroom had dust, debris, and cobwebs, and reported s/he would clean it.	{M 276}		
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 1 of 7 required locations. There was no smoke detector in the living room of the home. The smoke detector at the door to the enclosed stairway was emitting a chirping sound, indicating new batteries were required. Findings include:	M 334		

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M 334	Continued From page 7 On 01/07/2026, at 9:10 AM, Surveyors toured the home and identified the following: The living room did not have a smoke detector. A chirping sound was heard from the smoke detector located at the door leading to the enclosed stairway, which indicated it needed a change of batteries. On 01/07/2026, at approximately 1:00 PM, Surveyors interviewed House Manager (HM) G. HM G was unaware a smoke detector was needed in the living room of the home. S/He reported s/he would have one installed. Staff were responsible for conducting smoke detector testing throughout the home monthly. HM G was unaware the smoke detector leading to the enclosed stairway needed a change of batteries.	M 334		
{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	{M 424}		

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{M 424}	Continued From page 8 guardian. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 residents (Resident 1's and Resident 4's) individual service plans (ISPs) were reviewed and updated every 6 months and not updated to include behaviors and interventions. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) 352313, dated 03/26/2020; and SOD 352317, dated 05/15/2023. Findings include: On 01/07/2026 at 9:00 AM, Surveyors toured the facility. Surveyors noted metal bars on the outside of Resident 1's bedroom. Surveyors inquired from Caregiver H why there were bars on the window and were told that it was to try and prevent Resident 1 from leaving the facility through the window. Surveyors asked Caregiver H if any of the other residents had similar behaviors and were told that Resident 2 did not try to leave the facility but was known to have verbal and physical aggression. On 01/07/2026, Surveyors reviewed Resident 1 ' s and Resident 4 ' s ISPs. Resident 1 was admitted on 01/23/2017, Resident 1 has a guardian appointed for them. Resident 1's ISP was last completed and sent to the guardian for review in October of 2025. Resident 1's record contained a Behavior Service	{M 424}		

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{M 424}	Continued From page 9 Plan (BSP). Resident 1's BSP included Resident 1 is known to be verbally and physically aggressive, has made suicidal statements and is known to display sexually inappropriate behaviors. Resident 1's ISP did not mention these behaviors nor reference the BSP. Resident 1's ISP and BSP did not include information regarding using the bars on the windows as an intervention to prevent elopement. Resident 4 was admitted on 07/05/2023 and is his/her own person. Resident 4's ISP was last reviewed in April of 2025 and was overdue for a review. Resident 4's records contain a BSP that included Resident 4 is known to be verbally aggressive and use racial slurs, have physical aggression and damage property." Resident 4's ISP did not mention these behaviors nor reference the BSP. On 01/07/2026 at 10:30 AM, Surveyors interviewed Manager G. Manager G confirmed both Resident 1 and Resident 4 displayed the behaviors mentioned above. Manager G stated s/he did not know the behaviors needed to be addressed in the ISP.	{M 424}		
{M 458}	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	{M 458}		

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{M 458}	Continued From page 10 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medication was securely stored for 1 of 1 storage area. The home's medication closet was kept unlocked. This deficiency is being cited for a fifth time. See Statement of Deficiency (SOD) 352315, dated 10/13/2021; SOD 352316, dated 06/15/2022; SOD 352317, dated 05/15/2023, and SOD QUC011, dated 08/14/2023 Findings include: On 01/07/2026 at 9:30 AM, Surveyors toured the facility. An unlocked medication closet was observed in the hallway with resident medications including oral medications and inhalers for nebulization as well as dressing supplies contained inside it. On 01/07/2025 at 10:30 AM, Surveyors interviewed Manager G regarding the unlocked medication closet. Manager G stated that resident medication is usually stored in each resident's room in a locked cabinet, and demonstrated this to Surveyors. Manager G stated that the closet was meant more for "overflow storage" and for upcoming medications cycles. Manager G stated s/he could understand why the closet would need to be locked at all times when not in use.	{M 458}		
M 556	88.10(3)(e) Self-Direction	M 556		

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M 556	Continued From page 11 Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the resident right to self-direction was respected or promoted for 1 of 1 resident (Resident 1) in the home. The home had multiple locking mechanisms on both the front and back exit/entrance doors, and bars on multiple windows, preventing Resident 1 from freely exiting the facility. Findings include: The facility was licensed as an ambulatory/non-ambulatory home, serving up to 3 residents in the client groups advanced age, physically disabled, traumatic brain injury, public funding, developmentally disabled, and emotionally disturbed/mental illness. On 01/07/2026, at 9:20 AM, Surveyor conducted an onsite tour of the home and observed the following: Entrances/Exits	M 556		

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M 556	Continued From page 12 - The back interior door contained the following locking mechanisms: One deadbolt lock, a door handle lock, and a bolt lock at the bottom of the door on the frame. - The back storm door contained the following locking mechanisms: a hook and eye latch from the inner frame of the doorway to the storm door, a deadbolt lock, a door handle lock, and a metal rod placed through the door to the frame. - The front interior door contained the following locking mechanisms: One deadbolt lock, a door handle lock, and a bolt lock at the bottom of the door on the frame. - The front storm door contained the following locking mechanisms: a door handle lock, and a metal rod placed through the door to the frame. Windows - The windows in Resident 1's bedroom had bars across them on the interior. - One window in Resident 5's bedroom had bars across it on the interior. - One window in the kitchen and one window in the dining room had bars across them on the interior. On 01/07/2026, at approximately 10:00 AM, Surveyors reviewed Resident 1's individual service plan (ISP), dated 04/28/2025, and behavior support plan (BSP), dated 04/15/2025, and the following was identified: Resident 1 had a history of elopement/wandering,	M 556		

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M 556	Continued From page 13 and dangerous behaviors. A specific elopement protocol was in Resident 1's file. Nothing in Resident 1's file addressed extra door locks or bars on windows in the home as a prevention for Resident 1's eloping behaviors. On 01/07/2026, at 9:22 AM, Surveyors interviewed Caregiver H, and the following was reported: The extra locks on the back door were for Resident 1 to prevent elopement. Caregiver H was unaware of the metal rod being used as a lock in the storm door and reported s/he was not sure how to remove it. Caregiver H did remove the metal rod after approximately 3 minutes of trying to manipulate it. On 01/07/2026, at approximately 10:15 AM, Surveyors toured the home with HM G and conducted an interview throughout the tour. The following was reported: Resident 1 had behaviors and was an elopement risk. The home had bars on the windows to prevent Resident 1 from eloping through the windows. There were extra locking mechanisms on the entry/exit doors for security and to prevent Resident 1 from eloping.	M 556		