STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 07/01/2026, Surveyor conducted a standard survey, at New Outlook II Adult Family Home, an Adult Family Home (AFH) in Wauwatosa, WI. Six deficiencies were identified. Census:3	M 000		
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 2 service providers (Caregiver B) received training within 6 months after starting to provide care related to first aid. Findings include: On 07/01/2026, Surveyor reviewed Caregiver B's record and identified the following: -Caregiver B was hired on 05/27/2023. -Caregiver B's employee record did not contain evidence of first aid training.	M 244		

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
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 1 On 07/01/2026, at approximately 11:28 AM, Surveyor interviewed Licensee A. Licensee A confirmed Caregiver B did not have training related to first aid within 6 months of hire. Licensee A reported s/he did not realize Caregiver B did not have first aid training until Surveyor requested training documentation.	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. 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 1 of 1 service provider (Caregiver B) who required annual training. Caregiver B did not receive training related to health, safety, rights and treatment of residents in 2025. Findings include: On 07/01/2026, Surveyor reviewed Caregiver B's record and identified the following:	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 2 -Caregiver B was hired on 05/27/2023. -Caregiver B's record did not contain evidence of him/her receiving annual training related to health, safety, rights and treatment of residents in 2025. On 07/01/2026, at approximately 11:28 AM, Surveyor interviewed Licensee A. Licensee A confirmed Caregiver B's record did not contain evidence of receiving annual training related to health, safety, rights and treatment of residents in 2025. Licensee A reported s/he did not realize Caregiver B did not receive all his/her annual training in 2025 until Surveyor requested training documentation.	M 246		
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.	M 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 3 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. The smoke detector in Resident 2's bedroom was not in working condition. Findings include: On 07/01/2026, at approximately 10:38 AM, Surveyor conducted a tour of the facility with Licensee A and observed the following: -Licensee A tested Resident 2's smoke detector located on the ceiling of his/her bedroom, and it was not in working condition. On 07/01/2026, at approximately 1:48 PM, Surveyor interviewed Licensee A. Licensee A confirmed the smoke detector located on the ceiling of Resident 2's bedroom was not in working condition. Licensee A reported that smoke detectors are tested monthly. Licensee A reported smoke detectors had not been tested yet for the month of July 2026. Licensee A stated s/he would have the maintenance person install a new smoke detector in Resident 2's bedroom.	M 334		
M 392	88.06(2)(c)3 ALL CHARGES AND SECURITY DEPOSITS Charges for room and board and services and any other applicable expenses, and the amount of the security deposit, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a service agreement,	M 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 392	Continued From page 4	M 392		

indicating the charges for room and board and services, was provided for 3 of 3 residents (Resident 1, Resident 2 and Resident 3) reviewed.

Findings include:

On 07/01/2026, Surveyor reviewed residents' records and identified the following:

Resident 1
-Resident 1 was admitted to the provider's home on 08/15/2021.

-Resident 1's service agreement was signed by Resident 1 on 08/15/2021. Resident 1's service agreement did not include information regarding what costs would be charged for the resident's room and board or other services.

Resident 2
-Resident 2 was admitted to the provider's home on 01/06/2023.

-Resident 2 had a guardian.

-Resident 2's service agreement was signed by Resident 2's guardian on 11/04/2021. Resident 2's service agreement did not include information regarding what costs would be charged for the resident's room and board or other services.

Resident 3
-Resident 3 was admitted to the provider's home on 09/01/2023.

-Resident 3 had a guardian.

-Resident 3's service agreement was signed by Resident 3's guardian on 09/01/2023. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 392	Continued From page 5 3's service agreement did not include information regarding what costs would be charged for the resident's room and board or other services. On 07/01/2026, at approximately 12:33 PM, Surveyor interviewed Licensee A. Licensee A confirmed residents service agreements did not include information relating to specific charges for room and board and services. Licensee A reported s/he was not aware of the costs for residents' room and board and other services needed to be included in the service agreements.	M 392		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a description of services the licensee would provide to meet the assessed need for 3 of 3 residents (Resident 1, Resident 2 and Resident 3) reviewed. Resident 1's Individual Service Plan (ISP) did not include the level of supervision required in the home and community and transportation to his/her medical appointments. Resident 2's ISP did not include the level of supervision required in the home and community and vocational needs.	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 6 Resident 3's ISP did not include the level of supervision required in the home and community. Findings include: On 07/01/2026, Surveyor reviewed residents' records and identified the following: Resident 1 -Resident 1 was admitted to the provider's home on 08/15/2021. -Resident 1's ISP, dated 02/09/2026, documented the following: "Transportation - [Resident 1] can navigate the city independently by public transportation." -Resident 1's ISP did not include the level of supervision required in the home and community and transportation need to medical appointments. Resident 2 -Resident 2 was admitted to the provider's home on 01/06/2023. -Resident 2's ISP was dated 01/15/2026 and did not include the level of supervision required in the home and community and vocational needs. Resident 3 -Resident 3 was admitted to the provider's home on 09/01/2023. -Resident 3's ISP was dated 02/17/2026 and did not include the level of supervision required in the home and community.	M 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 7 On 07/01/2026, at approximately 10:13 AM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1's ISP did not reflect the above-mentioned information. Licensee A reported that Resident 1 can be in the home alone for 2-3 hours. Licensee A reported staff takes Resident 1 to all his/her medical appointments. On 07/01/2026 at 12:34 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 2's ISP did not reflect the above-mentioned information. Licensee A reported Resident 2 requires 24-hour supervision in the home. Licensee A reported Resident 2 works part-time and go to day program on Friday from 8:00 AM-2:00 PM. On 07/01/2026, at approximately 1:07 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 3's ISP did not reflect the above-mentioned information. Licensee A reported Resident 3 can be in the home alone for 2-3 hours.	M 412		
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 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)	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 8 (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 criminal complaint and, if convicted, a judgement of conviction related to a conviction of s. 940.19(1) Battery, for 1 of 1 caregiver (Caregiver B). Findings include: On 07/01/2026, Surveyor reviewed Caregiver B's record and identified the following:	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	7443 MILWAUKEE AVE WAUWATOSA, WI 53213

(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 9 -Caregiver B was hired on 05/27/2023. -Caregiver B's Background Information Disclosure (BID) was completed and signed by him/her on 05/27/2023. Caregiver B did disclose s/he was convicted of a crime (Misdemeanor 02/23/2022). -Caregiver B's Department of Justice (DOJ) record was requested and reported on 05/27/2023 and the following was identified: -"Date of offense: 02/13/2023... Charge: 940.19(1) - Battery... Disposition date: 09/23/2016. Sequence number: 01.. Charge severity: Misdemeanor. -Caregiver B's Caregiver Background Check (IBIS) record was requested and reported on 05/27/2023 and the following was identified: -No findings. -No denials. -No exclusions. -No rehabilitation review findings. -No professional credential, license or certificate found. -Caregiver B's record did not include a copy of the complaint and, if convicted, a judgement of conviction from the clerk of courts for the charge indicated on Caregiver B's background check. On 07/01/2026, at approximately 9:53 AM, Surveyor interviewed Licensee A. Licensee A reported s/he was responsible to complete background checks on staff. Licensee A reported s/he did not realize s/he did not obtain the criminal complaint and, if convicted, a judgement of conviction from the clerk of courts for the	Z 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016233	A. BUILDING: _____ B. WING _____	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW OUTLOOK II ADULT FAMILY HOME	**7443 MILWAUKEE AVE WAUWATOSA, WI 53213**

(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 10 charge indicated on Caregiver B's background check.	Z 010		