

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013853	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER HOMETOWN ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2 HERITAGE LANE BELLEVILLE, WI 53508		
(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
N 000	Initial Comments On 08/26/2025, Surveyor conducted a monitoring visit at Hometown Assisted Living, a CBRF located in Belleville, WI. As a result of the visit, 0 violations of Chapter 83 were issued. Census: 7 NOTE: Facility will be closing by 09/30/2025. Facility is working with care teams, families and the Department to facilitate placement for remaining residents.	N 000		

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

TITLE

(X6) DATE