

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/09/2024
NAME OF PROVIDER OR SUPPLIER WEST ALLIS ADULT FAMILY HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1139 S 56TH ST MILWAUKEE, WI 53214		
(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 04/02/2024, with information gathered through 04/09/2024, Surveyor conducted a verification visit and complaint investigation. No deficiencies identified. Complaint unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 3	{M 000}			

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

TITLE

(X6) DATE