STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019048	A. BUILDING: _____ B. WING _____	C 02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IBERIAS HOUSE OF HOPE LLC	**1920 MADERA ST WAUKESHA, WI 53189**

(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 02/02/2024, Surveyor conducted 1 complaint investigation at Iberias House of Hope LLC. No deficiencies were identified. On 02/02/2024, complaint #45413 was substantiated under deficiency N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication contained in Statement of Deficiency (SOD) IQO611, dated 12/14/2023 and issued 01/08/2024, and the CBRF was within the 45-day plan of correction period. Census: 7	N 000		

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