

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011173	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 09/28/2023
NAME OF PROVIDER OR SUPPLIER HOME HARBOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 OHIO ST RACINE, WI 53405		
(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	
{U 000}	INITIAL COMMENTS On 09/28/2023, Surveyor conducted a verification visit for Statement of Deficiencies J6S811, dated 01/06/2023, and CCZZ11, dated 03/01/2023, a standard survey, and 2 complaint investigations at Home Harbor. No deficiencies were identified. Two complaints were unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 100	{U 000}			

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

TITLE

(X6) DATE