

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/11/2026
NAME OF PROVIDER OR SUPPLIER HEAVENLY HANDS-PARK JABEZ LIVING CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2848 N 48TH ST MILWAUKEE, WI 53210		
(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 06/11/2026, Surveyor completed a verification visit via desk review for Heavenly Hands Park Jabez Living Center II. As a result, Statement of Deficiency RGZV11 was corrected, and no new deficiencies were identified. Lift letter has been added to the e-file.	{M 000}		

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

TITLE

(X6) DATE