

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 05/12/2026
NAME OF PROVIDER OR SUPPLIER HOME CARE SOLUTIONS AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 341 E SUMNER STREET HARTFORD, WI 53027		
(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 05/12/2026, Surveyors conducted two verification visits at Home Care Solutions at Home, an Adult Family Home (AFH) in Hartford, WI. No deficiencies identified. All citations from Statement of Deficiency (SOD) W0SR12, dated 10/20/2025 and SOD UNOG11, dated 11/10/2025 have been corrected. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}			

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

TITLE

(X6) DATE