

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/21/2026
NAME OF PROVIDER OR SUPPLIER HAMILTON HOUSE SENIOR LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE W76 N629 WAUWATOSA RD CEDARBURG, WI 53012		
(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 01/21/2026, Surveyor conducted two (2) complaint investigations at Hamilton House Senior Living Inc, Residential Care Apartment Complex. As a result of the survey 2 complaints were unsubstantiated, no deficiencies identified. Census: 57	U 000		

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

TITLE

(X6) DATE