

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/10/2026
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING AFH SITE 4		STREET ADDRESS, CITY, STATE, ZIP CODE W129N8465 REVERE DR MENOMONEE FALLS, WI 53051		
(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 06/10/2026, Surveyor conducted a verification visit at Exceptional Living AFH Site 4. No deficiencies were identified. All deficiencies from Statement of Deficiency (SOD) 2K7O11, dated 01/27/2026 were substantially corrected. Under statutory provisions of Wis. Stat. Chap 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}		

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

TITLE

(X6) DATE