

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/27/2026
NAME OF PROVIDER OR SUPPLIER REM WISCONSIN INC CRESTLINE			STREET ADDRESS, CITY, STATE, ZIP CODE 2506 CRESTLINE DR MADISON, WI 53704		
(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 05/27/2026, Surveyor conducted a verification visit at REM Wisconsin Inc Crestline, an AFH located in Madison, WI. As a result of the survey, 0 violation of Chapter DHS 88 was issued. One violation from previous Statement of Deficiency #2LVY14 dated 12/29/2025 was corrected. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.	{M 000}			

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

TITLE

(X6) DATE