

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/09/2025
NAME OF PROVIDER OR SUPPLIER AT HOME RESIDENTIAL SERVICES LLC LANC		STREET ADDRESS, CITY, STATE, ZIP CODE 5109 N 64TH ST MILWAUKEE, WI 53218		
(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 12/09/2025, Surveyors completed a verification visit and complaint survey. As a result of the survey, all deficiencies have been corrected. One of 1 complaint is unsubstantiated. Under statutory provisions of Wis. Stat. C. 50, a \$200 revisit fee is being assessed. Census: 2	{M 000}		

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

TITLE

(X6) DATE