Wisconsin Department of Health Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019738 | A. BUILDING: _____ B. WING _____ | R-C 10/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BROWN INDEPENDENT LIVING** | **111 4TH ST WAUKESHA, WI 53188** |

| (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<br><br>On 10/13/2026, Surveyor conducted a verification visit at Brown Independent Living.<br><br>No deficiencies were identified.<br><br>All previous violations from Statement of Deficiency (SOD) 5D2Q13, dated 04/29/2026 were substantially corrected.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.<br><br>Census: 2 | {M 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE