

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0020784</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/10/2026</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROYAL LEGACY ADULT FAMILY HOME LLC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1909 PARADISE STREET</b><br><b>WAUKESHA, WI 53188</b> |
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| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| M 000                    | <p><b>INITIAL COMMENTS</b></p> <p>On 07/10/2026, Surveyor conducted a complaint investigation at Royal Legacy Adult Family Home LLC.</p> <p>No deficiencies were identified.</p> <p>The complaint was unsubstantiated.</p> <p>Census: 3</p> | M 000               |                                                                                                                          |                          |

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