

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>0019680</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>12/04/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>UNBREAKABLE COMMITMENTS HOME AND H</b> |                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6860 W GRANTOSA DR<br/>MILWAUKEE, WI 53218</b> |                                                                                                                          |                                                                |
| (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                                       |
| {M 000}                                                                       | <b>INITIAL COMMENTS</b><br><br>On 12/04/2025, Surveyor conducted a verification<br>visit and 1 complaint investigation.<br>No deficiencies were identified.<br>One complaint was unsubstantiated.<br><br>Census: 03 | {M 000}                                                                                    |                                                                                                                          |                                                                |

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

TITLE

(X6) DATE