

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 03/05/2026
NAME OF PROVIDER OR SUPPLIER A BETTER LIVING FAMILY SERVICES SITE 3			STREET ADDRESS, CITY, STATE, ZIP CODE 9104 W CUSTER AVE MILWAUKEE, WI 53225		
(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 03/05/2026, Surveyor completed a survey, 2 complaint investigations, and a verification visit at A Better Living Family Services Site 3. As result, 4 of the previous 4 deficiencies were corrected. No new deficiencies were identified. Two complaints were unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee will be assessed. Census: 3	{M 000}			

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

TITLE

(X6) DATE