

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0018744</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 03/17/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SAVED BY GRACE FAITH ADULT FAMILY HOM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3845 NORTH 10TH STREET MILWAUKEE, WI 53206</b>
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(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	<p><b>INITIAL COMMENTS</b></p> <p>On 03/17/2025, Surveyor conducted 2 complaint investigations and a verification visit at Saved by Grace Faith Adult Family Home LLC, an AFH located in Milwaukee, WI.</p> <p>As a result of the survey, 0 violations of Chapter DHS 88 were issued.</p> <p>Both complaints were unsubstantiated.</p> <p>One violation from previous Statement of Deficiency (SOD) S3CO12 dated 06/25/2024 was corrected.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 3</p>	M 000		

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

TITLE

(X6) DATE