

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0021316</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/03/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>REMEDY HOME HEALTH LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>724 S LAYTON AVE MILWAUKEE, WI 53215</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
E 000	<p><b>INITIAL COMMENTS</b></p> <p>An announced initial remote survey was conducted 6/3/2025 with Remedy Home Health, an Adult Day Care Center in Milwaukee, WI.</p> <p>The agency is in compliance with WI Administrative Code DHS 105.14 for Adult Day Care Centers.</p> <p>Current enrollment: 0 Total square footage: 5768 Total maximum capacity per square footage allowed: 115 Current maximum capacity requested: 112</p> <p>There were no employee records to review.</p>	E 000		

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

TITLE

(X6) DATE