

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017817	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/22/2025
NAME OF PROVIDER OR SUPPLIER MY PLACE OF IXONIA III		STREET ADDRESS, CITY, STATE, ZIP CODE N8622A NORTH RD IXONIA, WI 53036		
(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 07/22/2025, the Bureau of Assisted Living, Southern Regional Office, conducted an abbreviated licensing survey at My Place of Ixonia III, an adult family home (AFH) located in Ixonia, WI. As a result of the survey, 0 deficiencies were identified. Census: 0	M 000		

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

TITLE

(X6) DATE