

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/26/2025
NAME OF PROVIDER OR SUPPLIER AUTUMN BAY OF PEWAUKEE		STREET ADDRESS, CITY, STATE, ZIP CODE 539 E WISCONSIN AVE PEWAUKEE, WI 53072		
(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
N 000	Initial Comments On 06/19/2025, with information gathered through 06/26/2025, Surveyor conducted 2 complaint investigations at Autumn Bay of Pewaukee, a CBRF located in Pewaukee, WI. There were 0 deficiencies of Chapter DHS 83 identified. Both complaints were unsubstantiated. Census: 18	N 000		

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

TITLE

(X6) DATE