

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018673	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER MISSION CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3217 FIDDLERS CREEK DRIVE WAUKESHA, WI 53188		
(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 10/10/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit for Statement of Deficiency (SOD) 6GWJ12, dated 05/03/2024, at Mission Creek, a community-based residential facility (CBRF) located in Waukesha, WI. As a result of the survey, 0 deficiencies were identified. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 74	N 000		

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

TITLE

(X6) DATE