

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390225	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ORCHARD VIEW ADULT FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE W6429 HWY 12 FORT ATKINSON, WI 53538		
(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 01/15/2025, the Bureau of Assisted Living, Southern Regional Office conducted a verification visit of statement of deficiency (SOD) EUFF11 at Orchard View Adult Family Home located at W6429 Hwy 12 in Fort Atkinson, WI. / No citations of noncompliance were issued. Two citations issued with SOD EUFF11 were substantially corrected. Census: 4 Under statutory provisions of Wis. Stat. Ch. 50, a \$200.00 revisit fee is being assessed.	{M 000}		

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

TITLE

(X6) DATE