Wisconsin Department of Health Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0012024 | A. BUILDING: _____ B. WING _____ | R-C 10/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WELLINGTON MEADOWS** | **525 MEMORIAL DR 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 |
|---|---|---|---|---|
| {N 000} | Initial Comments<br><br>On 10/14/2024, Surveyor conducted a verification visit at Wellington Meadows.<br><br>No deficiencies were identified.<br><br>The deficiency from Statement of Deficiency (SOD) FM0G12, dated 02/21/2024 was substantially corrected.<br><br>Under statutory provisions of Wis. Stat. Chap 50, a $200 revisit fee is being assessed.<br><br>Census: 27 | {N 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE