

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0016500</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/10/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NEXT INNING (THE)</b> |                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>506 N MAIN ST</b><br><b>ORFORDVILLE, WI 53576</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| N 000                                                        | <p>Initial Comments</p> <p>On 10/10/2024, the bureau of assisted living southern regional office conducted a standard survey &amp; complaint investigation at The Next Inning a CBRF located in Orfordville, WI.</p> <p>As a result of this survey, 0 violations of DHS Chapter 83 were issued.</p> <p>Complaint was unsubstantiated.</p> <p>Census: 11</p> | N 000                                                                                         |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE