

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/20/2024
NAME OF PROVIDER OR SUPPLIER OAK GROVE CBRF		STREET ADDRESS, CITY, STATE, ZIP CODE W3343 HOFFMAN RD 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 On 03/20/2024, Surveyor conducted a verification visit at Oak Grove CBRF. No deficiencies were identified. All deficiencies from statement of deficiency (SOD) I6Q12, dated 10/02/2023 were substantially corrected. Under statutory provisions of Wis. Stat. Chap 50, a \$200 revisit fee is being assessed. Census: 8	{N 000}		

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

TITLE

(X6) DATE