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
	0017445	A. BUILDING: _____ B. WING _____	R 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE OF IXONIA II	N8616B NORTH RD IXONIA, WI 53036

(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 11/06/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at My Place of Ixonia II, an adult family home (AFH) located in Ixonia, WI. As a result of the survey, zero deficiencies were identified. The previous deficiency from Statement of Deficiency (SOD) IJX312, dated 08/08/2024, was corrected. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		

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