

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/31/2025
NAME OF PROVIDER OR SUPPLIER AUTUMN FIELDS		STREET ADDRESS, CITY, STATE, ZIP CODE E426 CO RD SS LUXEMBURG, WI 54217		
(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 07/31/2025, Surveyor conducted 2 verification visits at Autumn Fields for Statement of Deficiencies (SOD) YSXZ13, dated 04/02/2025 and SOD JR5Q11, dated 04/23/2025. One of 1 deficiency for SOD YSXZ13 was corrected. Three of 3 deficiencies for SOD JR5Q11 were corrected. No new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 21	{N 000}		

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

TITLE

(X6) DATE