

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/10/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN CARE MADISON		STREET ADDRESS, CITY, STATE, ZIP CODE 6314 BETTYS LANE MADISON, WI 53711		
(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 05/10/2024, The bureau of assisted living southern regional office conducted a complaint investigation and standard survey at Golden Care Madison and AFH located in Madison, WI. As a result of this investigation, 0 violations of DHS Chapter 88 were identified Complaint was unsubstantiated Census: 2	M 000		

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

TITLE

(X6) DATE