

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/30/2024
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NAME OF PROVIDER OR SUPPLIER CHESTNUT ADULT FAMILY CARE HOM	STREET ADDRESS, CITY, STATE, ZIP CODE 415 W CHESTNUT PORT WASHINGTON, WI 53074
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(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 10/25/2024-10/30/2024, Surveyor conducted an abbreviated survey and complaint investigation at Chestnut Adult Family Care Home. No deficiencies were identified. The complaint was unsubstantiated. Census: 3	M 000		

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

TITLE

(X6) DATE