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
	0016801	A. BUILDING: _____ B. WING _____	R 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGATE REM WISCONSIN I INC	**4614 AGATE LANE MADISON, WI 53713**

(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 11/21/2023, The Bureau of Assisted Living, Southern Regional Office conducted an Enforcement Verification Visit at AGATE REM WISCONSIN I INC, an AFH located in Madison, WI. As a result of this survey, 0 violations of Chapter DHS 88 were issued. One violations from previous statement of deficiency (SOD) # KGYV13 dated 06/07/2023 was corrected. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed.	{M 000}		

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