

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015676	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/09/2023
NAME OF PROVIDER OR SUPPLIER AUTUMN OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 14087 198TH STREET JIM FALLS, WI 54748		
(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 11/07/2023, Surveyor conducted a verification visit at Autumn Oaks. Data was collected through 11/09/2023. The deficiency from SOD Q30Y12, dated 04/25/2023, was corrected. No other deficiencies were identified. Census: 3 Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.	{M 000}			

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

TITLE

(X6) DATE