

Wisconsin Department of Health Services

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|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017145</b>        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>R-C<br><b>01/15/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BISCHEL ADULT FAMILY HOME LLC</b> |                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>214 N MAIN ST<br/>CADOTT, WI 54727</b> |                                                                                                                          |                                                               |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                      |
| {M 000}                                                                  | <p><b>INITIAL COMMENTS</b></p> <p>On 01/15/2025, Surveyor completed a verification visit at Bischel Adult Family Home.</p> <p>No deficiencies were identified.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 3</p> | {M 000}                                                                            |                                                                                                                          |                                                               |

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

TITLE

(X6) DATE