

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016597	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/07/2026
NAME OF PROVIDER OR SUPPLIER J & B ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 GATEWAY PASS VERONA, WI 53593		
(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	
{N 000}	Initial Comments On 05/07/2026, Surveyor conducted a verification visit at J & B Assisted Living, a CBRF located in Verona, WI. As a result of the survey, 0 violations of Chapter DHS 83 were issued. Two violations from previous Statement of Deficiency (SOD) UHQH11 dated 04/23/2025. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.	{N 000}			

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

TITLE

(X6) DATE