

Wisconsin Department of Health Services

|                                                            |                                                                                                                                                                     |                                                                                                |                                                                                                                          |                                                        |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0012615</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/29/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HIL APPLE HOUSE</b> |                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1621 PREMIER PLACE<br/>FORT ATKINSON, WI 53538</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                               |
| N 000                                                      | <p>Initial Comments</p> <p>On 05/28/2025, Surveyor conducted an abbreviated survey at HIL Apple House.</p> <p>No deficiencies were identified.</p> <p>Census: 7</p> | N 000                                                                                          |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE