

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER MCFARLAND VILLA ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5206 PAULSON CT MC FARLAND, WI 53558		
(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 08/27/2025, Surveyor conducted a verification visits at McFarland Villa Assisted Living, a CBRF in McFarland. As a result of this survey, 0 violations of Chapter DHS 83 were issued. One (1) deficiency from previous statement of deficiency (SOD) # XL1G11, dated 04/30/2025 was substantially corrected. Under statutory provisions of Wis. Stat. Ch50, \$200 revisit fee is being assessed. Census: 34	{N 000}		

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

TITLE

(X6) DATE