

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>0013525</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>11/13/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADVANCED FAMILY HOME</b> |                                                                                                                                                                                                                                                                        |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1717 SOUTHERN RIDGE TRL</b><br><b>MADISON, WI 53719</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 11/13/2025, Surveyor conducted a verification visit at Advanced Family Home. No deficiencies were identified.</p> <p>Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 2</p> | {M 000}                                                                     |                                                                                                                          |                          |                                                                    |

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

TITLE

(X6) DATE