Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019899	A. BUILDING: _____ B. WING _____	09/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYLYNNE HOME	**5421 JOYLYNNE DR MADISON, WI 53716**

(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
M 000	INITIAL COMMENTS On 02/19/2024, Surveyor conducted an initial licensure at Joylynne Home in Madison WI. As of 02/19/2024, Joylynne Home will be known to the Department as license # 19899, a 3 bed ambulatory adult family home that can accept clients from the following client groups: developmentally disabled, alocohol/drug dependent, advanced aged, emotionally disturbed/mental illness, traumatic brain injury, irreversible dementia/Alzheimer's, and can accept public funding. The adult family home is HCBS compliant. Census 0	M 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE