STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019853	A. BUILDING: _____ B. WING _____	R 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE RECOVERY AND CONNECTION	7876 WOOD REED DR MADISON, WI 53719

(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 08/06/2025, Surveyor conducted a verification visit at Love Recovery and Connection, an AFH located in Madison, WI. As a result of the survey, 0 violations of Chapter DHS 88 were issued. One violation from previous Statement of Deficiency (SOD) 4S8O11 was corrected. Facility wishes to change licensure from Ambulatory to Non-Ambulatory. Facility meets the criteria for a Non-Ambulatory facility. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		

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