

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>0019538</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CASTLE MANOR VI LLC</b> |                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3130 SUNNY VIEW LN<br/>BROOKFIELD, WI 53005</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 11/28/2023, Surveyor conducted an initial licensure visit at Castle Manor VI, LLC.</p> <p>A regular license was issued effective 11/28/2023.</p> <p>The home is wheelchair accessible with ramped exits and accommodate up to 4 adults. The adult family home will be recognized by the Department as Facility ID #19538.</p> | M 000                                                                                       |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE