

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015785	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/13/2024
NAME OF PROVIDER OR SUPPLIER CCLS INC FAIRFIELD I		STREET ADDRESS, CITY, STATE, ZIP CODE 436 S FAIRFIELD AVE JUNEAU, WI 53039		
(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 06/13/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at CCLS Inc Fairfield I, an adult family home (AFH) located in Juneau, WI. As a result of the survey, 0 deficiencies were identified. Both deficiencies from Statement of Deficiency (SOD) H7CH11, dated 03/27/2024, were corrected. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}		

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

TITLE

(X6) DATE