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
	0018147	A. BUILDING: _____ B. WING _____	R 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FOR 1 INC	1170 GEORGES AVENUE BROOKFIELD, WI 53045

(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 10/30/2025, with information obtained through 10/31/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at All For 1 Inc, an adult family home (AFH) located in Brookfield, WI. As a result of the survey, 0 deficiencies were identified. All deficiencies from previous Statement of Deficiency (SOD) J7RJ13, dated 06/12/2025, were corrected. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		

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