

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>0013643</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TODDS ADULT FAMILY HOME</b> |                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WASHINGTON AVE<br/>OSHKOSH, WI 54901</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                                                              | <b>INITIAL COMMENTS</b><br><br>On 11/04/2024, Surveyor conducted an abbreviated survey at Todds Adult Family Home in Oshkosh. As a result, no deficiencies were identified.<br><br>Census: 4 | M 000                                                                                    |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE