

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>0014999</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SILVER STAR ADULT FAMILY HOME</b> |                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>W5991 LEE DRIVE<br/>FORT ATKINSON, WI 53538</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>INITIAL COMMENTS</p> <p>On 08/27/2026, the Bureau of Assisted Living,<br/>Southern Regional Office conducted an<br/>abbreviated licensing survey at Silver Star Adult<br/>Family Home in Fort Atkinson, WI.</p> <p>No citations of noncompliance were issued.</p> <p>Census: 3</p> | M 000                                                                                       |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE