

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/13/2024
NAME OF PROVIDER OR SUPPLIER ABOVE & BEYOND AFH III		STREET ADDRESS, CITY, STATE, ZIP CODE 5214 16TH ST MOUNT PLEASANT, WI 53406		
(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 03/13/2024, Surveyor conducted a verification visit at Above & Beyond AFH III for Statement of Deficiency (SOD) RRZT11 dated 12/22/2022. No deficiencies were identified. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}		

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

TITLE

(X6) DATE