

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>0017617</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/19/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADULT MENTAL HEALTH RESIDENTIAL CARE</b> |                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>34700 VALLEY RD<br/>OCONOMOWOC, WI 53066</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                               |
| N 000                                                                           | <p>Initial Comments</p> <p>On 02/19/2026, Surveyor conducted an abbreviated survey at Adult Mental Health Residential Care in Oconomowoc.</p> <p>No deficiencies were identified.</p> <p>Census: 12</p> | N 000                                                                                    |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE