

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0011712</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVALON SQUARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>222 PARK PL WAUKESHA, WI 53186</b>
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(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
U 000	<p><b>INITIAL COMMENTS</b></p> <p>On 07/30/2024, Surveyor conducted an abbreviated survey at Avalon Square.</p> <p>No deficiencies identified.</p> <p>Census: 48</p>	U 000		

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

TITLE

(X6) DATE