| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0009226 | A. BUILDING: _____ B. WING _____ | 02/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONE CREST RESIDENCE | 805 PARCHER ST WAUSAU, WI 54403 |

| (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 |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>On 02/17/2026, Surveyor conducted a desk review survey for Stone Crest Residence.<br><br>One deficiency was identified. | N 000 | | |
| N 141 | 83.09 Biennial report and fees.<br><br>Biennial report and fees. Every 24 months, on a date determined by the department, the licensee shall submit a biennial report on the form provided by department, and shall submit payment of the license continuation fees.<br><br>This Rule is not met as evidenced by:<br>Based on record review, the licensee did not submit a biennial report and payment of the license continuation fees. The licensee was operating with an expired license.<br><br>Findings include:<br><br>The provider was licensed for up to 16 residents in the client groups of: terminally ill, advanced age, physically disabled, and irreversible dementia/Alzheimer's disease.<br><br>On 02/17/2026, Surveyor reviewed the Department's electronic file for Stone Crest Residence. The provider's license expired approximately 5 months ago, on 08/31/2025.<br><br>On 06/25/2025, the Department emailed the provider a "LICENSE CONTINUATION" letter. The letter read, in part: "According to our records, your license is scheduled for review by the license continuation date listed below. Please review the enclosed Community Based | N 141 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0009226 | A. BUILDING: _____ B. WING _____ | 02/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONE CREST RESIDENCE | 805 PARCHER ST WAUSAU, WI 54403 |

| (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 |
|---|---|---|---|---|
| N 141 | Continued From page 1<br><br>Residential Facility Biennial Report. The completed Community Based Residential Facility Biennial Report, license fee, and this page must be submitted to the Regional Office no later than the payment due date listed below." The letter indicated the license continuation date was: 08/31/2025, and the payment due date was: 08/01/2025.<br><br>On 08/01/2025, the Department emailed the provider a "PAST DUE BIENNIAL REPORT AND/OR FEE PAYMENT" letter. This letter read, in part: "A review of your license must be completed every two years or when a probationary period expires. By email dated 06/25/2025, you were notified that your license continuation fee and biennial report were due by 08/01/2025. To date we have not received your license continuation fee payment and/or biennial report ... If the biennial report, license continuation fee, and late fees are not received by 08/31/2025, the Division of Quality Assurance will proceed with license revocation pursuant to Wisconsin Stats. § 50.03(4)(c)1."<br><br>On 09/23/2025, the Department emailed the provider, which read, in part: "The email below was sent for the renewal of STONE CREST RESIDENCE, 0009226. The license is now EXPIRED; therefore, the renewal report and payment will need to be submitted to the regional office."<br><br>On 09/23/2025, Administrator A and Person B confirmed with a read receipt email that they read the email sent on 09/23/2025.<br><br>As of 02/17/2026, the Department has not received the provider's biennial report or license continuation fees. The provider is operating with | N 141 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0009226 | A. BUILDING: _____ B. WING _____ | 02/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STONE CREST RESIDENCE** | **805 PARCHER ST WAUSAU, WI 54403** |

| (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 |
|---|---|---|---|---|
| N 141 | Continued From page 2<br>an expired license. | N 141 | | |