

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014122	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 02/25/2025
NAME OF PROVIDER OR SUPPLIER DELAWARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1725 DELAWARE ST OSHKOSH, WI 54902		
(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 02/25/2025, Surveyor conducted a verification visit at Delaware adult family home. Five (5) of 5 previous deficiencies were corrected and no new deficiencies were identified. Census: 3 Under statutory provisions of WI Stat. Ch. 50 a \$200 revisit fee is being assessed.	{M 000}			

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

TITLE

(X6) DATE