

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>0009118</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NEW BEGINNINGS ADULT FAMILY HOME</b> |                                                                                                                                                                                            |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>702 PLUMER STREET</b><br><b>WAUSAU, WI 54403</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 |                                                                    |
| M 000                                                                       | <p>INITIAL COMMENTS</p> <p>On 01/22/2024, Surveyor conducted a standard licensure survey at New Beginnings Adult Family Home.</p> <p>No deficiencies were identified.</p> <p>Census: 4</p> | M 000                                                                       |                                                                                                                          |                          |                                                                    |

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

TITLE

(X6) DATE