

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018752	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 11/05/2025
NAME OF PROVIDER OR SUPPLIER VITACARE LIVING SPOONER II			STREET ADDRESS, CITY, STATE, ZIP CODE W7184 GREEN VALLEY RD SPOONER, WI 54801		
(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 On 10/30/2025, Surveyors conducted a verification visit and complaint investigation at VitaCare Living Spooner II. Data was collected through 11/05/2025. Three of 3 complaints were unsubstantiated. The citations from Statement of Deficiency (SOD) BM8D11, dated 08/20/2025 were corrected. No new citations were identified. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 7	{N 000}			

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

TITLE

(X6) DATE