

Wisconsin Department of Health Services

|                                                                  |                                                                                                                                                                                      |                                                                             |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0012360</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ASPIRUS DUROY TERRACE</b> |                                                                                                                                                                                      |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>595 PETERSON DRIVE<br/>PHILLIPS, WI 54555</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                               |
| U 000                                                            | <b>INITIAL COMMENTS</b><br><br>On 01/31/2024, Surveyor conducted an abbreviated licensure survey at Aspirus Duroy Terrace.<br><br>No deficiencies were identified.<br><br>Census: 15 | U 000                                                                       |                                                                                                                          |  |                                                        |

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

TITLE

(X6) DATE