

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/29/2024
NAME OF PROVIDER OR SUPPLIER DUCE ADULT FAMILY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 6774 CTY HWY H STANLEY, WI 54768		
(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 08/27/2024, Surveyor conducted a complaint survey at Duce Adult Family Home. Data was collected through 08/29/2024. The complaint was unsubstantiated. No deficiencies were identified. Census: 4	M 000			

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

TITLE

(X6) DATE