

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011370	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/03/2025
NAME OF PROVIDER OR SUPPLIER WOLF RIVER COUNTRY ADULT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 13231 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 04/03/2025, Surveyor conducted a verification visit at Wolf River Country Adult Home. No deficiencies were identified. The deficiency identified in SOD K5EW13 was corrected. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}			

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

TITLE

(X6) DATE