

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0009607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/09/2025
NAME OF PROVIDER OR SUPPLIER DESTINY ADULT FAMILY HOME I		STREET ADDRESS, CITY, STATE, ZIP CODE 2419 JEAN AVE RACINE, WI 53403		
(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 12/09/2025, Surveyor completed 1 complaint investigation and a verification visit at Destiny Adult Family Home I. As a result, the previous 3 deficiencies were corrected. One Complaint was unsubstantiated. No new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee will be assessed. Census: 4	{M 000}		

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

TITLE

(X6) DATE