

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/21/2025
NAME OF PROVIDER OR SUPPLIER KRAMERS KOTTAGE FAMILY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 203702 N FREY AVENUE MARSHFIELD, WI 54449		
(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 04/21/2025, Surveyor conducted a verification visit at Kramers Kottage Family Home. The deficiencies from SOD RHIC11, dated 01/04/2024, were corrected. No new deficiencies were identified. Census: 4 Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.	{M 000}			

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

TITLE

(X6) DATE