

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/17/2025
NAME OF PROVIDER OR SUPPLIER STEWART ADULT FAMILY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 719 N FRANKLIN 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 12/17/2025, Surveyor completed a verification visit at Stewart Adult Family Home. No deficiencies identified. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 1	{M 000}			

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

TITLE

(X6) DATE