

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/04/2024
NAME OF PROVIDER OR SUPPLIER SERENITY LIVING 3 A TOUCH OF HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 720 S CYPRESS 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	
{N 000}	Initial Comments On 10/30/2024, Surveyor conducted an onsite visit at Serenity Living 3 A Touch of Home to conduct a verification visit. Additional information was gathered through 11/04/2024. The previous citations were corrected and no new deficiencies were identified. Census: 7 Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.	{N 000}			

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

TITLE

(X6) DATE