

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018392	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/07/2026
NAME OF PROVIDER OR SUPPLIER ST MARIA CRESENTIA CBRF			STREET ADDRESS, CITY, STATE, ZIP CODE 16770 WEST NORTH AVENUE BROOKFIELD, WI 53005		
(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 01/07/2026, Surveyor conducted a verification visit at St. Maria Crescentia CBRF. No deficiencies were identified. Two of 2 deficiencies from Statement Of Deficiency TMD211, dated 10/02/2025 were substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 8	{N 000}			

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

TITLE

(X6) DATE