

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/11/2025
NAME OF PROVIDER OR SUPPLIER WOOD ADULT FAMILY HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4406 WOOD RD MOUNT PLEASANT, 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 02/11/2025, Surveyor conducted a verification visit at Wood Adult Family Home. As a result, the previous 3 deficiencies were corrected, and no new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee will be assessed. Census: 3	{M 000}		

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

TITLE

(X6) DATE