

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0010279</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/10/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MAPLEWOOD VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1425 HEMLOCK STREET</b><br><b>SAUK CITY, WI 53583</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {U 000}                                                      | <p><b>INITIAL COMMENTS</b></p> <p>On 07/10/2025, Surveyor conducted a verification visit at Maplewood Village, a RCAC in Sauk City.</p> <p>No deficiencies were identified. Statement of Deficiency (SOD) TUO411, dated 01/22/2025, was corrected.</p> <p>Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed.</p> <p>Census: 24</p> | {U 000}                                                                                           |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE