

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019281	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 05/05/2026
NAME OF PROVIDER OR SUPPLIER 4 SEASONS AFH 3			STREET ADDRESS, CITY, STATE, ZIP CODE 800 MARTIN RD BLOOMER, WI 54724		
(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 05/05/2026, Surveyor completed a verification visit and standard survey at 4 Seasons AFH 3. No deficiencies were identified. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed Census: 4	{M 000}			

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

TITLE

(X6) DATE