Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019463	A. BUILDING: _____ B. WING _____	02/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HOME	**6225 SANDSTONE DR MADISON, WI 53719**

(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 02/19/2024, Surveyor conducted a complaint investigation at Sandstone Home in Madison WI. The complaint was substantiated without deficiencies. The adult family home will be known to the Department as license # 19643, a 4-bed ambulatory adult family home that can accept clients from the following client groups: Terminally ill, developmentally disabled, alcohol/drug dependent, pregnant women/counseling, correctional clients, emotionally disturbed/mental illness, advanced aged, irreversible dementia/Alzheimer's and can accept public funding. Census 0	M 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE