

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/06/2026
NAME OF PROVIDER OR SUPPLIER STONEY RIVER MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1606 N ST JOSEPH AVE MARSHFIELD, WI 54449		
(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 04/06/2026, Surveyor conducted an onsite visit to verify correction of one previous deficiency and to investigate a complaint. The previous deficiency was corrected. The complaint was unsubstantiated. No new deficiencies were identified. Census: 26 Under statutory provisions of WI Stat. Ch. 50 a \$200 revisit fee is being assessed.	{N 000}		

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

TITLE

(X6) DATE