

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017750	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/11/2026
NAME OF PROVIDER OR SUPPLIER SV NORTH NINE ACRES		STREET ADDRESS, CITY, STATE, ZIP CODE 229 VAN DYKE ST OCONTO, WI 54153		
(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 03/05/2026 with additional information obtained through 03/11/2026, Surveyor conducted a verification visit, 1 complaint investigation and a standard survey at SV North Nine Acres. As a result, 1 complaint was unsubstantiated, 3 of 3 deficiencies were corrected and no deficiencies were identified. Census: 15	{N 000}		

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

TITLE

(X6) DATE